

ISOSS hepatitis B positive antenatal notification

form date 06/23

CONFIDENTIAL

HOSPITAL NAME:

HOSPITAL CODE:

PART 1: MATERNAL DETAILS

I. Demographic information

Date of birth: ___/___/___

Soundex:

NHS no.:

Hospital no.:

GP name: Practice:

Not registered at GP

Gender the same as when registered at birth? Yes F, No M, No non-binary, No - other

Ethnic origin:

White

- British
 Irish
 Any other White background

Black or Black British

- Caribbean
 African
 Any other Black background

Other Ethnic Groups

- Chinese
 Any other ethnic group, please specify.....

Mixed

- White and Black Caribbean
 White and Black African
 White and Asian
 Any other mixed background

Asian or Asian British

- Indian
 Pakistani
 Bangladeshi
 Any other Asian background

Not stated

Home postcode (leave off last letter):

Country of birth: If country of birth not UK, date of arrival: ___/___/___

Exact date/year not known, timing: during pregnancy (date not known) <1 year prior to pregnancy

1-5 years prior to pregnancy 5-10 years prior to pregnancy >10 years prior to pregnancy

II. Social circumstances

Employment status at booking: Employed (full or part-time) Home Sick Student
 Unemployed Retired Voluntary Not known

Main support during pregnancy: Partner (cohabiting) Partner (not cohabiting) Family/friend
 Other None Not known

Employment status at booking: Employed (full or part-time) Home Sick Student
 Unemployed Retired Voluntary Not known N/A (no partner)

Any documented social/complicating issues (tick all that apply)?

- Housing concerns Intimate partner violence/domestic abuse Drug or alcohol misuse
 Mental health issues Immigration issues (incl refugee/asylum seeker) Prison/detention centre
 Sex work Social services involvement/safeguarding Learning difficulties Not engaging with healthcare services Financial concerns (incl accessing foodbank)
 None

Other, details:

Does the woman speak English? Yes No

If yes, is English her first language? Yes No, what is her first language?.....

Were translation services required? No Yes*

*If yes, was a formal interpreter used? Yes, details of service:

No, reason

Which language did the woman require translation service for?

III. Obstetric history

Gravida..... Parity.....+..... Date(s) of previous livebirths if known: _____

Obstetric history not known

PART 2: PREGNANCY DETAILS

Woman known to have booked at another hospital in this pregnancy? No Yes, details

Woman known to be transferring her pregnancy care to another hospital? No Yes, details

.....

Date booked for antenatal care at your hospital: ___/___/___ <input type="checkbox"/> Unbooked (arrived in labour)			
Was there a delay to the woman being booked <input type="checkbox"/> No <input type="checkbox"/> Yes, reason			
Maternal weight at booking kg		maternal height at booking cm	
Is this an IVF pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known			
Estimated date of delivery (by ultrasound): ___/___/___ and/or LMP: ___/___/___			
Pregnancy status: <input type="checkbox"/> Continuing to term <input type="checkbox"/> Miscarriage* – date: ___/___/___ at weeks gestation <input type="checkbox"/> Termination* – date: ___/___/___ at weeks gestation *If miscarriage or termination, any congenital conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes:			
PART 3: ANTENATAL HEPATITIS B SCREENING			
Was infectious diseases screening offered and accepted for <u>all</u> infections? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason.....			
Is this a new diagnosis of hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when was the diagnosis of hep B given? (if info available, please provide year).....			
Date screening sample taken: ___/___/___			
Was HBV diagnosis a result of the IDPS screening? <input type="checkbox"/> Yes <input type="checkbox"/> No, details.....			
Date screening result (HBsAg) reported to the screening team by the laboratory: ___/___/___			
Previously screened negative in <i>this</i> pregnancy? <input type="checkbox"/> date of screen negative result ___/___/___			
PART 4: THE SCREENING ASSESSMENT VISIT			
Date first seen by a member of the screening team: ___/___/___			
Was the result given to the woman within 5 working days? <input type="checkbox"/> Yes <input type="checkbox"/> No, See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women) reason:			
Was this appointment: face to face <input type="checkbox"/> virtual via phone <input type="checkbox"/> virtual other <input type="checkbox"/> , details.....			
Referral made to specialist team (e.g. Hepatology/Gastroenterology)? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:			
If not referred is she already under care of specialist team who are aware she is pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has the hepatitis B maternal and neonatal checklist commenced? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:			
Has the woman been given/been directed to the UKHSA leaflet 'Hepatitis B. A guide to your care in pregnancy and after your baby is born' : <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:			
Has antenatal surveillance sample been taken and sent to Colindale? Yes/No, reason:			
Has the 3rd trimester review visit been arranged? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason:			
Has a notification letter/communication been sent to:			
GP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Child Health Records Department? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Health visitor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Blood results			
Is this considered to be acute hepatitis B infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Please provide test results from screening sample/earliest results in pregnancy:			
<u>Type of test</u>	<u>Date of test</u>	<u>Result</u>	
		positive	negative
HBV surface antigen (HBsAg)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HBV e antigen (HBeAg)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HBV e antibody (anti-HBe)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HBV DNA (viral load)	___/___/___	_____ IU/ml*	

*if result not given in IU/ml please state the units

(info button): Please indicate in the notes if you don't have access to one or more of these results (with a reason)

Infectivity classification (as reported by virologist/laboratory)

Lower infectivity Higher infectivity

If higher infectivity, was HBIG been ordered: Yes/No, reason:.....

Concurrent maternal infection(s)? None Syphilis HCV HIV Other, specify:

PART 5: CLINICAL MANAGEMENT

Date first seen by specialist team: ____/____/____

Name of specialist.....

Type of specialist: Hepatology gastroenterologist clinical nurse specialist other (please specify).....

If new diagnosis / higher infectivity, was the woman seen within 6 weeks of referral ([IDPS S06 standard](#))

Yes No, reason..... N/A

If lower infectivity, was the woman seen within the 18week NHS outpatient department target? Yes No, reason..... N/A

Was this woman on hepatitis B treatment at conception? Yes No

Details of treatment (please include all drugs and start dates):

PART 6: ADDITIONAL INFORMATION

Empty box for additional information.