**CONFIDENTIAL**

HOSPITAL NAME: HOSPITAL CODE:

HOSP

**ISOSS hepatitis B positive antenatal notification**

***form date 07/21***

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| **PART 1: MATERNAL DETAILS** |
| I. Demographic information |
| **Date of birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Soundex:** ……………. |
| **NHS no.:** …………………………………… | **Hospital no.:** ………………………………. |
| **GP name: ………………………………………………………… Practice: …………………………………………………..****Not registered at GP** [ ]   |
| **Ethnic origin:** |
| ***White***[ ]  British [ ]  Irish[ ]  Any other White background***Mixed*** [ ]  White and Black Caribbean[ ]  White and Black African[ ]  White and Asian[ ]  Any other mixed background | ***Black or Black British***[ ]  Caribbean[ ]  African[ ]  Any other Black background***Asian or Asian British***[ ]  Indian[ ]  Pakistani[ ]  Bangladeshi[ ]  Any other Asian background | ***Other Ethnic Groups***[ ]  Chinese[ ]  Any other ethnic group[ ]  Not stated |
| **Home postcode (leave off last letter):** □□□□ □□■ |
| **Country of birth:** …………………………………………  **If country of birth not UK, date of arrival:** \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 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 [ ]  Drug or alcohol misuse [ ]  Mental health issues [ ]  Immigration problems [ ]  Prison [ ]  Sex work [ ]  Social services involvement [ ]  Learning difficulties [ ]  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 ……………………………………………………………………………………………………………………  |
| III. Obstetric history |
| ***Previous pregnancies***…….. **livebirth(s)**, date(s) if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **stillbirth(s)** | …….. **miscarriage(s)/TOP(s) ……..** |
| **PART 2: PREGNANCY DETAILS** |
| **Date referral received by maternity:** \_\_\_\_/\_\_\_\_/\_\_\_\_  | **Date booked for antenatal care:** \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| **Maternal weight at booking** ………... kg **maternal height at booking** ………... cm  |
| **Is this an IVF pregnancy?** [ ]  Yes [ ]  No[ ]  Not known |
| **Estimated date of delivery (by ultrasound):** \_\_\_\_/\_\_\_\_/\_\_\_\_ and/or **LMP:** \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| **Pregnancy status:** [ ]  Continuing to term[ ]  Miscarriage\* – date: \_\_\_\_/\_\_\_\_/\_\_\_\_ at .……. weeks gestation [ ]  Termination\* – date: \_\_\_\_/\_\_\_\_/\_\_\_\_ at .……. weeks gestation \*If miscarriage or termination, any congenital abnormality? [ ]  No [ ]  Yes: …………………………………………….. |
| **PART 3: ANTENATAL HEPATITIS B SCREENING**  |
| **Is this a new diagnosis of hepatitis B?** [ ]  Yes [ ]  No **If no, when was the diagnosis of hep B given?** (if info available, please provide year)**………………..**Date screening sample taken: …./…./…..Date screening sample tested: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date screening result (HBsAg) reported to the screening team by the laboratory: …../…../…..  |
| **PART 4: THE SCREENING ASSESSMENT VISIT** |
| **Date first seen by a member of the screening team:** \_\_\_\_/\_\_\_\_/\_\_\_\_ [See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women](https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards))If more than 10 working days between report of result and appointment, reason: …………………………………..…………………………………………………………………………………………………………………………………………… |
| **Referral made to specialist team (e.g. Hepatology/Gastroenterology)?**  ☐ Yes ☐ No, reason: …………………………………………………………………………………………………………………………………………… |
| **Has the hepatitis B maternal and neonatal checklist commenced?** ☐Yes ☐ No, reason: …..………………………………………………………………………………………………………………………………………. |
| **Has the woman been given/been directed to** [**the PHE leaflet ‘Hepatitis B. A guide to your care in pregnancy and after your baby is born’**](https://www.gov.uk/government/publications/protecting-your-baby-against-hepatitis-b-leaflet/hepatitis-b-a-guide-to-your-care-in-pregnancy-and-after-your-baby-is-born)**:** ☐Yes ☐ No, reason: …………………………………………………………………………… |
| **Has antenatal surveillance sample been taken and sent to PHE Colindale?** ☐Yes ☐ No, reason: ………………………………………………………………………………………………………………………………………….. |
| **Has the 3rd trimester review visit been arranged?** ☐Yes ☐ No, reason:………………………………………………………………………………………………………………………………………….. |
| **Has a** [**notification letter/communication**](https://www.gov.uk/government/publications/hepatitis-b-notification-letters) **been sent to:****GP?** ☐Yes ☐ No, reason:………………………..…………………………………………………………………**Child Health Records Department?** ☐Yes ☐ No, reason:…………………………………………………… **Health visitor?** ☐Yes ☐ No, reason:……………………………………………………………………………… |
| Blood results |
| Is this considered to be acute hepatitis B infection? ☐Yes ☐ No ☐ Unknown |
|  **Type of test** | **Date of test** | **Result** |  |
|  |  | **positive** | **negative** |
|  HBV e antigen (HBeAg) | \_\_\_\_/\_\_\_\_/\_\_\_\_ |  [ ]  |  [ ]  |
|  HBV e antibody (anti-HBe) | \_\_\_\_/\_\_\_\_/\_\_\_\_ |  [ ]  |  [ ]  |
|  HBV DNA (viral load) | \_\_\_\_/\_\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_IU/ml |
| **Have samples been taken for:** |  |  |
|  | **Yes** |  **No** | **Not known** |
|  Full blood count (FBC)?  |  [ ]  |  [ ]  |  [ ]  |
|  Urea & electrolytes (U&E)? |  [ ]  |  [ ]  |  [ ]  |
|  Liver Function Tests (LFTs)? |  [ ]  |  [ ]  |  [ ]  |
|  Clotting? |  [ ]  |  [ ]  |  [ ]  |
|  Hepatitis C? |  [ ]  |  [ ]  |  [ ]  |
| **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: ……………………………………..…………………………………………………………………………………………………….\*please inform us if Covid-19 has been suspected/diagnosed in the pregnancy |
| **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**](https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards)**)** ☐Yes ☐ No, reason……………………………………….. ☐ N/A |
| **If lower infectivity, was the woman seen within the 18week NHS outpatient department target?** ☐Yes ☐ No, reason: ……………………………………….. ☐ N/A |
| **PART 6: ADDITIONAL INFORMATION** |
| COVID-19 vaccine received ☐Yes ☐ NoIf 'Yes', please specify below which vaccine, number of doses and dates if known………………………………………………………………………………. |

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