**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 ☐ No  If 'Yes', please specify below which vaccine, number of doses and dates if known  ………………………………………………………………………………. | | | | | | | | | | |

**Please return using nhs.net secure email**