EPID 394 (Rev NOV 2013)

Kentucky Reportable Disease Form

Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001

Hepatitis Infection in a Pregnant Woman, Infant, or Child (aged five years or less)
Fax Form to 502-564-4760

DEMOGRAPHIC DATA

Patient's Last Name	First	M.I.	Date of Birth	Age	Gender ☐ M ☐ F ☐ Unk

Address	City	State	Zip	County of Residence

Phone Number	Patient ID Number	Ethnic Origin ☐ Hisp. ☐ Non-Hisp.	Race ☐W ☐B ☐A/PI ☐Am. Ind. ☐Other

DISEASE INFORMATION

Describe Clinical Symptoms:	Date of Onset: / /	Jaundice: ☐Yes ☐No	Date of Diagnosis: / /

Is Patient Pregnant? ☐Yes ☐No If yes, # wks_____	Expected Date of Delivery: / /	Name of Hospital for Delivery:

Physician Provider Name: Address: Phone:		

LABORATORY INFORMATION

Hepatitis Markers	Results	Date of test	Viral Load *if applicable	Name of Laboratory
HBsAg	☐ Pos ☐ Neg	/ /		
IgM anti-HBc	☐ Pos ☐ Neg	/ /		
HBeAg	☐ Pos ☐ Neg	/ /		
IgM anti-HAV	☐ Pos ☐ Neg	/ /		
HCV Antibody	☐ Pos ☐ Neg	/ /		
HCV RNA Confirmation	☐ Pos ☐ Neg	/ /		

SERUM AMINOTRANSFERASE LEVELS

Patient	Reference	Date of test	Name of Laboratory
AST (SGOT) U/L	U/L	/ /	
ALT (SGPT) U/L	U/L	/ /	

Mother: Hepatitis Risk Factors
☐IDU ☐Multiple Sexual Partners ☐Tattoos ☐STD
☐HIV ☐Foreign Born/ Country _____
☐Exposure to known HBV/HCV Pos contact

Child: Hepatitis Risk Factors
☐Mother HBV Pos ☐Household member exposure HBV Pos
☐ Mother HCV Pos ☐Household member exposure HCV Pos
☐Foreign Born / Country_____

Mother: Hepatitis A vaccination history: ☐Yes ☐No ☐Refused Dates Given: _____ _____
Hepatitis B Vaccination history: ☐Yes ☐No ☐Refused
If yes, how many doses ☐1 ☐2 ☐3 Year completed: / /
Child: Hepatitis A vaccination history: ☐Yes ☐No ☐Refused Dates Given _____ _____

Hepatitis B Vaccination history: ☐Yes ☐No ☐Refused Dates Given: _____ _____ _____
Was PEP for Infant of Positive HBV mother given at birth? ☐Yes ☐No

Kentucky UNBRIDLED SPIRIT