



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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk
Address		City	State	Zip	County of Residence
Phone Number	Patient ID Number	Ethnic Origin <input type="checkbox"/> Hisp. <input type="checkbox"/> Non-Hisp.		Race <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other	

DISEASE INFORMATION			
Describe Clinical Symptoms:	Date of Onset: / /	Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Diagnosis: / /
Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
IgM anti-HBc	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
HBeAg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
IgM anti-HAV	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
HCV Antibody	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	/ /		
HCV RNA Confirmation	<input type="checkbox"/> Pos <input type="checkbox"/> 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 <input type="checkbox"/> IDU <input type="checkbox"/> Multiple Sexual Partners <input type="checkbox"/> Tattoos <input type="checkbox"/> STD <input type="checkbox"/> HIV <input type="checkbox"/> Foreign Born/ Country _____ <input type="checkbox"/> Exposure to known HBV/HCV Pos contact	Child: Hepatitis Risk Factors <input type="checkbox"/> Mother HBV Pos <input type="checkbox"/> Household member exposure HBV Pos <input type="checkbox"/> Mother HCV Pos <input type="checkbox"/> Household member exposure HCV Pos <input type="checkbox"/> Foreign Born / Country _____
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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

