

Initial Notification Form for Pregnant Women who are hepatitis B Positive

Specialist Midwife to send to Public Health Department after first hospital appointment

<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">Patient Details <small>(Addressograph if available)</small></td> </tr> <tr><td>Name</td><td>_____</td></tr> <tr><td>Address</td><td>_____ _____</td></tr> <tr><td>Postcode</td><td>_____</td></tr> <tr><td>Phone no:</td><td>_____</td></tr> <tr><td>Mobile no:</td><td>_____</td></tr> <tr><td>D.O.B</td><td>__/__/__ CHI _____</td></tr> <tr><td>Language</td><td>_____</td></tr> <tr><td>GP Name</td><td>_____</td></tr> <tr><td>Practice</td><td>_____ _____</td></tr> <tr><td>Phone no:</td><td>_____</td></tr> </table>	Patient Details <small>(Addressograph if available)</small>		Name	_____	Address	_____ _____	Postcode	_____	Phone no:	_____	Mobile no:	_____	D.O.B	__/__/__ CHI _____	Language	_____	GP Name	_____	Practice	_____ _____	Phone no:	_____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">Other Details</td> </tr> <tr><td>Estimated Due Date</td><td>__/__/__</td></tr> <tr><td>Booking sample date</td><td>__/__/__</td></tr> <tr><td>Serology results:</td><td style="text-align: right;">Date</td></tr> <tr><td> HBsAg:</td><td>_____ __/__/__</td></tr> <tr><td> Anti-HBc:</td><td>_____ __/__/__</td></tr> <tr><td> anti-HBe:</td><td>_____ __/__/__</td></tr> <tr><td> HBeAg:</td><td>_____ __/__/__</td></tr> <tr><td> load:</td><td>_____ __/__/__ Viral</td></tr> <tr><td>Mother requires antivirals</td><td style="text-align: right;">YES / NO</td></tr> <tr><td>Baby to receive</td><td style="text-align: right;">Vaccination HBIG</td></tr> <tr><td>Confirmed with Virology</td><td style="text-align: right;">__/__/__</td></tr> </table>	Other Details		Estimated Due Date	__/__/__	Booking sample date	__/__/__	Serology results:	Date	HBsAg:	_____ __/__/__	Anti-HBc:	_____ __/__/__	anti-HBe:	_____ __/__/__	HBeAg:	_____ __/__/__	load:	_____ __/__/__ Viral	Mother requires antivirals	YES / NO	Baby to receive	Vaccination HBIG	Confirmed with Virology	__/__/__
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Obstetric History:				
Names of other children (if this is not first child)	GP	D.O.B	CHI	Vaccination status
		__/__/__		
		__/__/__		
		__/__/__		
		__/__/__		
		__/__/__		

Names of household / sexual contacts	Relationship	GP	D.O.B	CHI	Vaccination status
			__/__/__		
			__/__/__		
			__/__/__		
			__/__/__		
			__/__/__		

	Are these contacts aware of this patient's hepatitis B diagnosis? YES / NO
	Has the patient given permission for these contacts to be followed up for testing and vaccination? YES / NO

Any other important information: _____ _____
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Please forward the completed form to: Health.protection@nhsllothian.scot.nhs.uk