



County of San Diego

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Perinatal Hepatitis B Prevention Program REPORTING HBsAg POSITIVE RESULTS IN PREGNANCY

The Perinatal Hepatitis B Prevention Program (PHBPP) conducts case management for HBsAg-positive women who are pregnant.

If your office has identified that a pregnant woman you are taking care of is Hepatitis B positive, please fill out the information on page 2 and send it to us as soon as possible.

Please fax the requested information to (619) 692-5677 or send us an encrypted email to PHS-PerinatalHepB.HHSA@sdcounty.ca.gov.

Note:

Health care providers are required to report HBsAg positive pregnant women to the LHD where the case resides [Title 17, CCR § 2500 (b)]. Providers are mandated to test pregnant women for HBsAg (California Health and Safety Code, Section 125085). The HBsAg test should be ordered at an early prenatal visit during each pregnancy.



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 3255 Camino del Rio South, San Diego, CA 92108
 Main: 866-358-2966 | Fax: 619-692-5677
 Email: PHS-PerinatalHepB.HHSA@sdcounty.ca.gov

PATIENT INFORMATION

Name: _____ Date of Birth: _____

HBsAg Positive Lab Collection Date: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Patient Address _____

Patient Phone: (Home) _____ (Work): _____ (Other): _____

PATIENT PREGNANCY STATUS

Is the patient *PREGNANT*?

YES, patient is pregnant. **Number of Pregnancies (G)** _____ **Number of living children (P)** _____

NO, Last Menstrual Period (LMP): _____

DON'T KNOW, Last Menstrual Period (LMP): _____

If Last Menstrual Period (LMP) is **UNKNOWN**, please indicate date of and reason for last visit:

Date of last visit: _____

Reason for last visit: _____

If patient IS pregnant, please completely fill out the following information. If unknown, please indicate "UNKNOWN" in the appropriate field.

Delivery Hospital: _____ Expected Date of Delivery (EDD): _____

Delivery Physician Name & Address: _____

Delivery Physician Phone#: _____ Delivery Physician's Fax#: _____

Patient's Preferred Language: _____ Patient's Country of Birth: _____

Will patient be returning to their country of birth (If not U.S.) after delivery? Yes No Unknown

Type of Health Insurance: Medi Cal Unknown Cash
 Private Insurance Uninsured / Low Income

HBV DNA Result*: _____ Result Date: _____

*The American Association for the Study of Liver Diseases (AASLD) recommends maternal antiviral therapy when HBV DNA is >200,000 IU/mL; screening all HBsAg-positive women for HBV DNA guides the use of maternal antiviral therapy during pregnancy. Please include HBV DNA test report with this document upon return of fax.

Please Note:

The information contained in this transmittal, together with any attachment(s), is intended only for the use of the individual or entity to which it is addressed. It may contain information that is legally privileged, confidential, and prohibited from disclosure to any other party or parties under applicable law. If you are not the intended recipient, you are hereby notified that any review, copying, dissemination, disclosure or taking of any action in reliance on the contents of this message or any attachment(s) is strictly prohibited. If you have received this transmittal in error, please notify the original sender immediately by telephone or by return fax and arrange to have this transmittal, together with any attachment(s) returned or destroyed. Thank you.

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