County of San Diego

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HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
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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.