



EPID 394

Revised 5/2025

Kentucky Reportable Disease Form**Department for Public Health, Division of Epidemiology and Health Planning**
275 East Main St., Mailstop HS2E-A**Hepatitis Infection in Pregnant Women or Child (HBV- aged two years or less & HCV- aged three years or less)**
Report HBV/HCV electronically or by fax using EPID394.**Fax reports to 502-564-4760**

Date report submitted: _____ Agency Report Submitted by: _____ Agency Contact Phone Number: _____

NEWBORN INFANT BORN TO MOTHER WITH HBV/HCV OR CHILD AGED ≤ 2 for HBV and ≤ 3 for HCV

Infant/ Child: Last Name	First	M.I.	Date of Birth:	Gender:	Neonatal Abstinence Syndrome:	HBV Vaccine Given at Birth:
			/ /	Male Female	Yes No Unknown	Yes No Unknown
Address:			City:	State:	Zip:	County of Residence:
						Infant/Child lives with:
						Mother Foster Parent Adopted Other: _____
Infant/ Child Medical Record #:	Ethnic Origin:	Race:	Birth Weight:	Mother's Current Legal Last Name: First: M.I.		
	Hisp. Non-Hisp.	* W B A AI PI	lbs. oz.			
Insurance Status:			Is the Department Community Based Services Involved:			Guardian's Name/ Telephone Number:
Private Medicaid Uninsured Unknown			Yes No If Yes, Case Number: _____			

PREGNANT/ POST PARTUM MOTHER INFORMATION

Current Legal Last Name: First: M.I.: Maiden:	Is Patient Pregnant: Yes No	Is Patient Post-Partum: Yes No	Date of Birth:
	Expected Date of Delivery: / /	If yes, Date of Delivery: / /	/ /
Address: City: State: Zip: County of Residence:		Ethnic Origin:	Race:
		Hisp. Non-Hisp.	* W B A AI PI
Mother's Medical Record #:	Social Security #:	History of Incarceration:	Name of Physician / Hospital for Delivery:
	- -	Yes No Unknown	Address:

WOMAN/ POST PARTUM OR CHILD LABORATORY INFORMATION

Hepatitis Markers	Results	Date of Test	Viral Load (if applicable)	Name of Laboratory	Mother or Child:
HBsAg	Pos Neg Unk	/ /			
HB Surface anti-HBs	Pos Neg Unk	/ /			
IgM anti-HBc	Pos Neg Unk	/ /			
HBeAg	Pos Neg Unk	/ /			
IgM anti-HAV	Pos Neg Unk	/ /			
HCV Antibody ** See Below	Pos Neg Unk	/ /			
HCV RNA Confirmation ** See Below	Pos Neg Unk	/ /			

SERUM CAINOTRANSFERASE LEVELS

Mother or Child:	Reference:	Date of Test:	Name of Laboratory:
AST (SGOT) U/L	U/L	/ /	
ALT (SGPT) U/L	U/L	/ /	

Mother Hepatitis C Risk Factors:

IV Drug Use	Yes No Unknown	Internal Drug Use	Yes No Unk	Tattoos	Yes No Unknown
STI History	Yes No Unknown	HIV	Yes No Unk	Foreign Born? Country:	_____
Multiple Sex Partners	Yes No Unknown	HCV Contact Exposure	Yes No Unk		

Child Hepatitis B or C Risk Factors:

Mother HBV Positive	Yes No Unknown	HBV Contact Exposure	Yes No Unknown
Mother HCV Positive	Yes No Unknown	HCV Contact Exposure	Yes No Unknown

Mother Vaccination History:

Hepatitis A Vaccination History: Yes No Unknown Refused

Hepatitis B Vaccination History: Yes No Unknown Refused

If Yes, how many doses 1 2 3 Dates Completed: Dose 1: / / Dose 2: / / Dose 3: / /

Child Vaccination History:

Hepatitis A Vaccination History: Yes No Unknown Refused

Hepatitis B Vaccination History: Yes No Unknown Refused

If Yes, how many doses 1 2 3 Dates Completed: Dose 1: / / Dose 2: / / Dose 3: / /

Infants born to mothers with HBV, was HBIG given: Yes No Unknown If Yes, Date Given: / /

* Race: W – White B – Black A – Asian AI – American Indian or Alaska Native PI – Pacific Islander

** HCV Antibody should not be performed at birth for infant, due to presence of maternal antibodies. HCV antibody testing with reflex RNA testing at ≥ 18 months.

*** HCV RNA confirmation is recommended for infants born to mothers with an active HCV infection. KY DPH and CDC recommends NAT for HCV RNA at 2-6 months.

If interested in reporting electronically, please reach out to KHIESupport@ky.gov on how to enroll in the direct data entry for hepatitis reporting.