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: Male Female	Neonatal Abstinence Syndrome: Yes No Unknown	HBV Vaccine Given at Birth: 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: Hisp. Non-Hisp.	Race: * W B A AI PI	Birth Weight: lbs. oz.	Mother's Current Legal Last Name: First: M.I.

Insurance Status: Private Medicaid Uninsured Unknown	Is the Department Community Based Services Involved: Yes No If Yes, Case Number: _____	Guardian's Name/ Telephone Number:

PREGNANT/ POST PARTUM MOTHER INFORMATION

Current Legal Last Name: First: M.I.: Maiden:	Is Patient Pregnant: Yes No Expected Date of Delivery: / /	Is Patient Post-Partum: Yes No If yes, Date of Delivery: / /	Date of Birth: / /

Address: City: State: Zip: County of Residence:	Ethnic Origin: Hisp. Non-Hisp.	Race: * W B A AI PI	Telephone Number:

Mother's Medical Record #:	Social Security #: - -	History of Incarceration: Yes No Unknown	Name of Physician / Hospital for Delivery: 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 Unknown	/ /			
HB Surface anti-HBs	Pos Neg Unknown	/ /			
IgM anti-HBc	Pos Neg Unknown	/ /			
HBeAg	Pos Neg Unknown	/ /			
IgM anti-HAV	Pos Neg Unknown	/ /			
HCV Antibody ** See Below	Pos Neg Unknown	/ /			
HCV RNA Confirmation ** See Below	Pos Neg Unknown	/ /			

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

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.