EMTCT Hepatitis B: Case Investigation Form

HB_.01.2025

Name of the STD clinic:_____ Mother's file number : _____

Baby's file number : _____

Completed by (name & designation): _____ Date :_____

Note: Fill this form to all Hepatitis B confirmed pregnant women registered in the clinic

A. Details of the pregnant woman with Hepatitis B infection			
1. Age in years			
2. District of residence			
3. Nationality	1. Sri Lankan 2. Foreign (country:_____)		
4. Ethnicity			
5. Risk & vulnerability factors (e.g. FSW, DU, Psychosocial etc.)			
6. Past obstetric history (Parity, miscarriages, still births etc.			
7. Date of Hep B confirmation			
8. Diagnosed during current pregnancy	1. Yes 2. No		
9. HBeAg status	2. Positive 2. Negative		
Details of the current pregnancy			
10. LRMP		11. EDD	
12. POA of pregnancy at registration		13. POA at registering for EMTCT services	
14. 1st VL count during this pregnancy & date		15. 1st Hep B profile during this pregnancy & date	
16. Other relevant diagnosis (HIV/Syphilis/other)		17. Date of TDF/TAF initiation	
18. TDF started her own health or PMTCT	1. Own health 2. PMTCT	19. Viral load closest to 28 weeks of POA	
20. Viral load closest to delivery			
21. Post partum maternal TDF/TAF continue until	1. Delivery 2. 3 months 3. 6 months 4.Other (specify)		
Details of the sexual partner/s & family member			
22.Partners Hep B status		23.If Negative vaccinated or not	
24. Partners details	1. Risk factors (DU, MSM ….) 2.Occupation		
25. Household contacts screened or not/Vaccinated			
B. Details of the baby			
26. Date of birth		27. Facility/Place of birth	
28. Mode of delivery		29. Gestational age at delivery	
30. Baby's birth weight			
31. Birth dose of Hep B vaccine given at birth			
32. Hep B immunoglobulin given at birth	Yes ( ) No ( )		
33. Hep B vaccination at 2months		Date	
4 months		Date	
6 months		Date	
34. Final HBsAg at 12 months			

Other relevant information (Describe attempts to follow-up, adherence if available):

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