

Perinatal Hepatitis B Prevention Program CASE MANAGEMENT REPORT

COUNTY

MOTHER INFANT CONTACT (complete information on page 3)

MOTHER'S INFORMATION

MOTHER'S name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

Language spoken _____

Translator Name _____ Translator Phone _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Alternate contact name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

DEMOGRAPHICS

MOTHER'S Date Of Birth ____/____/____
m d y

or, if unknown, Age _____

Country Of Birth _____

Mother's Ethnicity/Race

- Hispanic yes no unknown
 White Am. Indian/Alaska Native
 Black Nat. Hawaiian/Pac. Islander
 Asian Refused to answer
 Unknown Other _____

SOURCES OF REPORT (check all that apply)

- Lab
 Infection Control Practitioner
 Physician

Name: _____

Phone: _____

Date: ____/____/____
m d y

Reported mother to delivery hospital's Infection Control on
____/____/____
m d y

Delivery hospital contact name

Phone _____

MOTHER'S HISTORY

HBsAg test result (during this pregnancy)

Positive Negative Not Done Date ____/____/____
m d y

Lab Name _____

Trimester when screened for hepatitis B

1st 2nd 3rd at delivery

EDD ____/____/____
m d y

OB Name _____

HBsAg: Positive Negative Not Done Date ____/____/____
m d y

Known Acute Hep B: Yes No

Date of Diagnosis ____/____/____
m d y

Known chronic carrier: Yes No

Date of Diagnosis ____/____/____
m d y

CASE CLOSURE

Case closed Date ____/____/____

Service completed

Lost to follow-up

Refused services

Moved out of county

Pregnancy ended

Other _____

Hepatitis B case report on mother sent to Immunization Program on ____/____/____ by (name) _____ Phone _____
m d y

NOTES



Perinatal Hepatitis B Prevention Program CASE MANAGEMENT REPORT

INFANT'S INFORMATION

INFANT'S NAME _____

Sex female male

Date of birth / /
 m d y

Delivery Hospital _____

Infant's Ethnicity/Race

- Hispanic yes no unknown
 White Am. Indian/Alaska Native
 Black Nat. Hawaiian/Pac. Islander
 Asian Refused to answer
 Unknown Other _____

PEDIATRICIAN INFORMATION

Name _____

Address _____
Street City Zip

Phone: _____

INFANT'S VACCINATION RECORD

Vaccine Type	Date	Vaccine Brand	Vaccine Brands
HBIG	<u> </u> / <u> </u> / <u> </u> m d y	_____	(enter # to indicate brand)
HB Vax 1	<u> </u> / <u> </u> / <u> </u> m d y	_____	1. Recombivax
HB Vax 2	<u> </u> / <u> </u> / <u> </u> m d y	_____	2. Engerix-B
HB Vax 3	<u> </u> / <u> </u> / <u> </u> m d y	_____	3. Pediarix
HB Vax 4	<u> </u> / <u> </u> / <u> </u> m d y	_____	4. Comvax
HB Vax 5	<u> </u> / <u> </u> / <u> </u> m d y	_____	5. Unknown
HB Vax 6	<u> </u> / <u> </u> / <u> </u> m d y	_____	

INFANT'S SEROLOGY

Date Serology Completed: / /
 m d y

HBsAg Result Pos Neg Unknown

If positive, date reported to ACDP / /
 m d y

Anti-HBs Result >10 mIU/ml Yes No Unknown

Lab Name _____

CASE CLOSURE

- Case closed Date / /
 m d y
- Service completed Moved out of county
 Lost to follow-up Parent refused follow-up
 Physician refuses follow-up Other _____

Hepatitis B case report on infant sent to Immunization Program on / / by (name) _____ Phone _____
 m d y

Notes



Perinatal Hepatitis B Prevention Program CASE MANAGEMENT REPORT

CONTACT'S INFORMATION

Copy for additional contacts

CONTACT'S name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

Relationship of contact to mother _____

DEMOGRAPHICS

CONTACT'S Date Of Birth / /
m d y

or, if unknown, Age _____

Country Of Birth _____

Contact's Ethnicity/Race

- Hispanic yes no unknown
 White Black Am. Indian/Alaska Native
 Asian Nat. Hawaiian/Pac. Islander Refused to answer
 Unknown Other _____

Pre-Vaccination Serology Test Results

Date of blood draw / /
m d y

HBsAg Pos. Neg. Not done

Anti-HBc Pos. Neg. Not done

Anti-HBs Pos. Neg. Not done

Contact's Vaccination Information

Vaccine Dose 1 Date / /
m d y

Vaccine Dose 2 Date / /
m d y

Vaccine Dose 3 Date / /
m d y

Post Vaccination Serology Test Results

Collection Date: / /
m d y

HBsAg Result Pos Neg

Anti-HBs Result >10 mIU/ml Yes No
 Unknown

Date serology completed / /
m d y

Lab name _____

CONTACT CASE CLOSURE

FOLLOW-UP

Could not be located Moved to _____

Refused further treatment Other _____

Hepatitis B case report on contact sent to Immunization Program on / / by (name) _____ Phone _____
m d y

Notes