Print Form

HEPATITIS B PERINATAL PREVENTION CASE REPORT FORM

Version 1

CLIENT INFORMATION

Last Name	First Name	Date of Birth (Mo/Da/Yr)

EDSS Number	County	Mom's Country of Birth

# Previous Live Births	Insurance	Insurance Provider	Primary Language
	Unknown		

CONTACT INFORMATION

Emergency Contact		Anchor Contact	
Name	Phone number	Name	Phone number

DELIVERY INFORMATION

Current Expected Delivery Date	Expected Delivery Hospital	County	Hospital Notified?
			Unknown

PHYSICIAN INFORMATION

Physician's Name (OB/GYN)	Clinic	Phone

Physician's Name (Pediatrician)	Clinic	Phone

INFANT INFORMATION #1

Last Name	First Name	Date of Birth	Time of Birth
			___:___ A/P

HBIG		Hepatitis B Vaccine				Date Screened*	Test Results	
		1		2	3			
(Mo/Da/Yr)	Time	(Mo/Da/Yr)	Time	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs
	__:__ A/P		__:__ A/P				Positive	

	Hepatitis B Vaccine			Date Screened*	Test Results		Status
Revaccinate **	4	5	6				1
	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs	1. Services Completed
Yes					Positive		2. Moved out of state
							3. Moved out of country
							4. Infant died
							5. Refused to participate
							6. Unable to locate
							7. Miscarriage
							8. Other

*The screening on the infant should be done 3-9 months after completion of the hepatitis B series

**Revaccinate only if both HBsAg and Anti-HBs are negative

If more than one infant complete next page

If only one infant complete contacts information on 3rd page

Due to personal identifying information,
please fax completed form to 877-427-7318
If questions, please call 877-427-7317

HEPATITIS B PERINATAL PREVENTION CASE REPORT FORM

Mom EDSS number _____

INFANT INFORMATION #2								
Last Name		**First Name**		**Date of Birth**			**Time of Birth**	
							___:___ A/P	
HBIG		**Hepatitis B Vaccine**				**Date Screened***	**Test Results**	
		1		2	3			
(Mo/Da/Yr)	Time	(Mo/Da/Yr)	Time	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs
	__:__ A/P		__:__ A/P				Positive	

Re-vaccinate **	Hepatitis B Vaccine			Date Screened*	Test Results		**Status**
	4	5	6				1
	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs	*see choices below*
Yes					Positive		

INFANT INFORMATION #3								
Last Name		**First Name**		**Date of Birth**			**Time of Birth**	
							___:___ A/P	
HBIG		**Hepatitis B Vaccine**				**Date Screened***	**Test Results**	
		1		2	3			
(Mo/Da/Yr)	Time	(Mo/Da/Yr)	Time	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs
	__:__ A/P		__:__ A/P				Positive	

Re-vaccinate **	Hepatitis B Vaccine			Date Screened*	Test Results		**Status**
	4	5	6				1
	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs	*see choices below*
Yes					Positive		

INFANT INFORMATION #4								
Last Name		**First Name**		**Date of Birth**			**Time of Birth**	
							___:___ A/P	
HBIG		**Hepatitis B Vaccine**				**Date Screened***	**Test Results**	
		1		2	3			
(Mo/Da/Yr)	Time	(Mo/Da/Yr)	Time	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs
	__:__ A/P		__:__ A/P				Positive	

Re-vaccinate **	Hepatitis B Vaccine			Date Screened*	Test Results		**Status**
	4	5	6				1
	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	HBsAg	Anti-HBs	1. Services Completed
Yes					Positive		2. Moved out of state
							3. Moved out of country
							4. Infant died
							5. Refused to participate
							6. Unable to locate
							7. Miscarriage
							8. Other

*The screening on the infant should be done 3-9 months after completion of the hepatitis B series

**Revaccinate only if both HBsAg and Anti-HBs are negative

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HEPATITIS B PERINATAL PREVENTION CASE REPORT FORM

Mom EDSS number _____

CONTACT INFORMATION #1						
Last Name	First Name		Relationship to Case*			Date of Birth (Mo/Da/Yr)
Date Screened (Mo/Da/Yr)	Test Results		Hepatitis B Vaccine			County
			1	2	3	
	HBsAg	Anti-HBc	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	
	Positive					

CONTACT INFORMATION #2						
Last Name	First Name		Relationship to Case*			Date of Birth (Mo/Da/Yr)
Date Screened (Mo/Da/Yr)	Test Results		Hepatitis B Vaccine			County
			1	2	3	
	HBsAg	Anti-HBc	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	
	Positive					

CONTACT INFORMATION #3						
Last Name	First Name		Relationship to Case*			Date of Birth (Mo/Da/Yr)
Date Screened (Mo/Da/Yr)	Test Results		Hepatitis B Vaccine			County
			1	2	3	
	HBsAg	Anti-HBc	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	
	Positive					

CONTACT INFORMATION #4						
Last Name	First Name		Relationship to Case*			Date of Birth (Mo/Da/Yr)
Date Screened (Mo/Da/Yr)	Test Results		Hepatitis B Vaccine			County
			1	2	3	
	HBsAg	Anti-HBc	(Mo/Da/Yr)	(Mo/Da/Yr)	(Mo/Da/Yr)	
	Positive					

*Relationship to case

1. Biological Father
2. Child of case
3. Sexual Contact
4. Household, other
5. Family member, other (not living in same house)
6. Unknown

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