

California Perinatal Hepatitis B Prevention Program

Mail to: Perinatal Hepatitis B Prevention Program
 Immunization Branch
 California Department of Public Health
 850 Marina Bay Parkway
 Building P, 2nd Floor
 Richmond, CA 94804

OR Fax to: (510) 620-3949

Case/Household Identification No.

____ - ____ - ____
County mm yy

Pregnant HBsAg+ MOTHER

- New Report Update False Positive Final Report/Closed
- Transfer (specify TO and FROM below) **For Out of State Transfers, fax to State PHPP ASAP**

To: (county/state) _____ From: (county/state) _____ Date: _____

If this case transferred from another county, what was that county's ID Number? ____ - ____ - ____

1. County: _____ 2. Date County initiated report ____/____/____
mm dd yyyy 3. SSN ____ - ____ - ____
if available

4. Name: _____
Last First MI

5. Mother's date of birth ____/____/____ 6. Mother's age when screened _____ 7. EDD ____/____/____
mm dd yyyy mm dd yyyy

8. City _____ 9. Zip _____

10. Pregnancy Outcome Live Birth(s), number: _____ Miscarriage/Abortion
 Fetal Death(s), number: _____ Unknown

If miscarriage/abortion is selected, then form is complete. Send to CDPH.

11. Is this the first case/household management report submitted to CA Perinatal Hep. B Prog. on this mother?

Yes No (include previous ID number: ____ - ____ - ____) Unknown

12. Source of HBsAg+ report (check all that apply)

Laboratory Prenatal care provider Delivery hospital Unknown Other (Specify): _____

13. Is Mom a known Chronic Hepatitis B Carrier?

Yes No Unknown

14. Is mom currently taking anti-viral medication for Hepatitis B?

Yes No Unknown

15. Diagnostic tests (If repeat tests were done on different dates, attach additional pages and complete tests section only)

| | Positive | Negative | Unknown | Date of test | Comments |
|-------------------------------------|--------------------------|--------------------------|--------------------------|----------------|----------|
| a. HBsAg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____ | _____ |
| b. anti-HBc | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____ | _____ |
| c. HBeAg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____ | _____ |
| d. anti-HBe | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____ | _____ |
| e. Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____ | _____ |
| f. HBV DNA (describe results) _____ | | | | ____/____/____ | _____ |

16a. Planned delivery hospital?

Name: _____

City: _____

16b. Prenatal Care Provider:

MD Name: _____

Clinic Name: _____

City: _____ Phone: _____

Mother's MRN: _____

17. Country of mother's birth U.S.A. Other, Specify: _____ Unknown

18a. Race: (Check all that apply)

- White
- Black
- Amer. Indian/ Alaskan Native
- Other/Unspecified

Asian (check all that apply)

- Chinese
- Japanese
- Korean
- Filipino
- Asian Indian
- Cambodian (non-Hmong)

- Thai
- Laotian (non-Hmong)
- Vietnamese (non-Hmong)
- Hmong
- Mien
- Other Asian: _____

Pacific Islander (check all that apply)

- Guamanian
- Samoan
- Native Hawaiian
- Tongan
- Other Pacific Islander: _____

18b. Ethnicity:

- Hispanic
- Non-Hispanic
- Unknown

19. Initial submit date: ____/____/____
mm dd yyyy

20. Close date: ____/____/____
mm dd yyyy

Person completing form: _____

Date: _____

Agency: _____

Phone: _____

California Perinatal Hepatitis B Prevention Program

Case/Household Identification No. _____
County mm yy

Name: _____
Last First MI

Birth date: ____/____/____
mm dd yyyy

Second Series Immunization and Repeat Post-Vaccination Serology Record:

17. a. If 'Neg', did infant receive a 2nd series of vaccine?

1 Yes 2 No 9 Unknown

b. Hep B Vac1 ____/____/____
mm dd yyyy

c. Hep B Vac2 ____/____/____
mm dd yyyy

d. Hep B Vac3 ____/____/____
mm dd yyyy

18. a. Was HBsAg test done after 2nd series?

1 Yes 2 No 9 Unknown

b. Date done ____/____/____
mm dd yyyy

c. Result: 1 Pos 2 Neg 9 Unknown

19. a. Was Anti-HBs test done after 2nd series?

1 Yes 2 No 9 Unk

b. Date done ____/____/____
mm dd yyyy

c. Result: 1 Pos 2 Neg 9 Unknown

Lost to Follow-up (for mother and infant):

20a. When was the mother/infant lost to follow-up?

Before infant was born During vaccination series Before PVS testing completed

Date of last contact: ____/____/____ (approximate) Never contacted

20b. Check all reasons mother and infant were lost to follow up (check all that apply)

Infant could never be located due to incorrect contact information

Infant moved out of the state: (If box is checked, please complete the CDPH Out-of-State Transfer Form)

Date moved: ____/____/____

Infant moved out of the country:

Date moved: ____/____/____ Country: _____

Compliance problem with family (i.e, uncooperative, refused PEP)

Was case reported to Child Protective Services? (If yes, please notify CDPH immediately and submit a copy of the CPS report).

1 Yes 2 No 9 Unknown

Infant died – date of death: _____, time of death (if available) _____

cause of death: _____

Other (specify): _____

General Comments:

NOTE: If further comments are necessary, please attach a separate page with additional information

Person completing form: _____ Date: _____

California Perinatal Hepatitis B Prevention Program Confidential HBsAg+ Case/Household Management Report

Household Contacts

1. Case/Household Identification No. _____
County mm yy _____

2. All Household Contacts

- a. _____ Total number of household contacts identified (a = b+c+d+j+k)
- b. _____ Number already known to be chronically infected or immune due to prior infection of Hep B
- c. _____ Number previously immunized
- d. _____ Number seroscreened for Hep B markers (usually anti-HBc)
 - e. _____ Of those seroscreened, number age ≤ 5 years
 - f. _____ Of those seroscreened, number age ≥ 6 years
 - g. _____ Of those seroscreened, number found to be already infected or immune
 - h. _____ Of those seroscreened, number found to be susceptible (i.e. negative for Hep B markers)
 - i. _____ Of those found to be susceptible, number vaccinated
- j. _____ Number vaccinated without screening
- k. _____ Number lost to follow-up

3. Household Contacts Receiving Immunization (list in any order)

Please enter the codes in () into the spaces below.

| | a. | b. | c. | d. | e. |
|-----------|-----------------|--|---|---|---|
| | Name (optional) | Age: 0-5 yrs (1); 6-21 yrs (2); ≥22 yrs. (3) | Hep B Vac 1 given? Yes (1); No (2); Unk (9) | Hep B Vac 2 given? Yes (1); No (2); Unk (9) | Hep B Vac 3 given? Yes (1); No (2); Unk (9) |
| Contact 1 | | | | | |
| Contact 2 | | | | | |
| Contact 3 | | | | | |
| Contact 4 | | | | | |
| Contact 5 | | | | | |
| Contact 6 | | | | | |

4. Lost to Follow-Up

If any of the household contacts listed above does not complete the 3-dose series, check all of the reasons that apply.

- a. Contact(s) located but later lost to follow-up
- b. Contact(s) found to be already infected or immune after series was started
- c. Contact(s) moved to another county within the state for follow-up and don't know whether vaccination series was completed or not
- d. Contact(s) moved out of the state
- e. Contact(s) moved out of the country
- f. Contact(s) died
- g. Compliance problem with family
- h. Other (specify): _____

Person completing form: _____

Date: _____

Agency: _____

Phone: _____

California Perinatal Hepatitis B Prevention Program

Confidential HBsAg+ Case/Household Management Report

Case/Household Identification No. _____
County mm yy

Optional worksheet (Do not send to State)

Name _____

Household address(es)/phone(s) _____

Translator needed? YES NO Mother's language _____

Staff person assigned to case/household _____ Delivery hospital _____

Provider type _____ Provider type _____

Physician name _____ Physician name _____

Clinic address(es) _____ Clinic address(es) _____

Phone(s) _____ Phone(s) _____

Infant(s) Dates Doses Due/Given=

| |
|-------|
| Due |
| Given |

| Name(s) | Date of Birth | HBIG/Vac #1 | Vac #2 | Vac #3 | Vac 4 | PVS* |
|---------|---------------|-------------|--------|--------|-------|------|
| 1. | | | | | | |
| 2. | | | | | | |

*Post Vaccination Serology Testing

Household Contacts Dates Doses Due/Given=

| |
|-------|
| Due |
| Given |

| Name(s) | DOB | Sex | Date Referred | Serology Results | Vac #1 | Vac #2 | Vac #3 | Notes |
|---------|-----|-----|---------------|------------------|--------|--------|--------|-------|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |