

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

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

- New Report Update False Positive In-State Transfer
- Infected Infant PEP Error Closed Out-of-State Transfer to state: _____

(For Infected Infants, PEP Errors & Out of State Transfers, fax report to State PHPP ASAP)

Pregnant HBsAg+ Mother

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

2. County: _____ 3. Date this report initiated ____/____/____ 4. SSN _____
if available

5. Name: _____
Last First MI

6. Mother's date of birth ____/____/____ 7. Mother's age when screened _____ 8. EDD ____/____/____
mm dd yyyy mm dd yyyy

9. City _____ 10. Zip _____

11. Was this case transferred from another county? 11a. If yes, what was that county's ID number:
1 Yes 2 No 9 Unknown
County mm yy

12a. Is this the first case/household management report submitted to CA Perinatal Hep. B Prog. on this mother?
1 Yes 2 No (include previous ID number: ____-____-____-____) 9 Unknown

13. Source of HBsAg+ report (check all that apply)
1 Laboratory 2 Prenatal care provider 3 Delivery hospital 9 Unknown
5 Other (Specify): _____

14a. Was HBsAg+ known before this pregnancy? 14b. If "Yes", was this discovered in connection with a previous pregnancy?
1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown

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

16a. Planned delivery hospital?
Name: _____
City: _____

16b. If mother is a Kaiser patient, include
Kaiser Medical Record Number: _____
Case ID Number: _____
(for Northern CA Kaiser Perinatal Program)

17. Country of mother's birth 1 U.S.A. 2 Other, Specify: _____ 9 Unknown

18a. Race: (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian/ Alaskan Native <input type="checkbox"/> Other/Unspecified	Asian (check all that apply) <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Filipino <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian (non-Hmong)	<input type="checkbox"/> Thai <input type="checkbox"/> Laotian (non-Hmong) <input type="checkbox"/> Vietnamese (non-Hmong) <input type="checkbox"/> Hmong <input type="checkbox"/> Mien <input type="checkbox"/> Other Asian: _____	Pacific Islander (check all that apply) <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Tongan <input type="checkbox"/> Other Pacific Islander: _____
18b. Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			

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

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

Person completing form: _____ Date: _____

Agency: _____ Phone: _____

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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:

16. a. If 'Neg', did infant receive a 2nd series of vaccine?
1 Yes 2 No 9 Unknown

17. a. Was HBsAg test done after 2nd series?
1 Yes 2 No 9 Unknown

b. Hep B Vac1 _____
mm dd yyyy

b. Date done _____
mm dd yyyy

c. Hep B Vac2 _____
mm dd yyyy

c. Result: 1 Pos 2 Neg 9 Unknown

d. Hep B Vac3 _____
mm dd yyyy

18. 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):

- 19a. Lost before infant was born
- during vaccination series
- before PVS testing completed

19b. Check all reasons mother and infant were lost to follow up (check all that apply)

- Hospital birth records available, but infant could never be located
- Infant moved or transferred to another county within the state for follow-up
- Infant moved out of the state : new address: _____
 no forwarding address available
- Infant moved out of the country
- Compliance problem with family (i.e, uncooperative, refused PEP)
- Infant died – date of death: _____, time of death (if available) _____
- Other (specify): _____
- Physician did not order post-vaccination serological testing
- Funding problem (i.e, lack of insurance, incomplete reimbursement)

If needed, please use this space to explain why mother and/or infant were lost to follow-up:

Other Remarks:

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

Person completing form: _____

Date: _____

Agency: _____

Phone: _____

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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): _____

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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.								