California Perinatal Hepatitis B Prevention Program

Confidential HBsAg+ Case/Household Management Report

If a PEP error occurs, please complete Part I of form and fax to (510) 620-3949 within 5 business days

Post-Exposure Prophylaxis (PEP) Errors

☐ New Report ☐ Update **County:** _____

Attach any lab reports and relevant medical records available for this mother and infant

Part I

Case/Household Identification Number

___-___-___-____ (county of origin)
County mm yy

MOTHER'S Name:

_____
Last First MI

MOTHER'S date of birth

____/____/_____
mm dd yyyy

INFANT'S Name:

_____
Last First MI

INFANT'S date of birth

____/____/_____
mm dd yyyy

Time of Birth

____:____
(Military Time: hh:mm)

Birth Hospital Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

HBIG ☐ Not given ☐ Given

Date and time when given ____/____/_____, ____:____
mm dd yyyy (military, hh:mm)

If date/time not available, age in hrs when given ____

Hep B Vac1 ☐ Not given ☐ Given

Date and time when given ____/____/_____, ____:____
mm dd yyyy (military, hh:mm)

If date/time not available, age in hrs when given ____

Please describe why the PEP error occurred in as much detail as possible:

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

PART II - When post-vaccination serological testing is complete, update this section and resend form

HBsAg test done? ☐Yes ☐No ☐Unk

If 'Yes', date done ____/____/_____ (m dd yyyy)

Result: ☐Pos ☐Neg ☐Unk

Anti-HBs test done ☐Yes ☐No ☐Unk

If 'Yes', date done ____/____/_____ (mm dd yyyy)

Result: ☐Pos ☐Neg ☐Unk

Reason PVS Testing not completed

(NOTE: do not close out a case as "lost to follow up" until CDPH staff review and designate this case as such):

Person completing form: _____ Date: _____

Agency: _____ Phone: _____