California Perinatal Hepatitis B Prevention Program

Mail to: Perinatal Hepatitis B Prevention
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** ___/___/_____ (mm/dd/yyyy) 6. **Mother's age when screened** _____ 7. **EDD** ___/___/_____ (mm/dd/yyyy)

8. **City** _____ 9. **Zip** _____

10. **Pregnancy Outcome** 1☐ Live Birth(s), number: _____ 3☐ Miscarriage/Abortion
2☐ Fetal Death(s), number: _____ 9☐ 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?**
1☐ Yes 2☐ No (include previous ID number: ___-___-___-____) 9☐ Unknown

12. **Source of HBsAg+ report (check all that apply)**
1☐ Laboratory 2☐ Prenatal care provider 3☐ Delivery hospital 9☐ Unknown 4☐ Other (Specify):_____

13. **Is Mom a known Chronic Hepatitis B Carrier?**
1☐ Yes 2 ☐ No 9 ☐ Unknown

14. **Is mom currently taking anti-viral medication for Hepatitis B?**
1☐ Yes 2 ☐ No 9 ☐ 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	☐	☐	☐	____/____/_____	
b. anti-HBc	☐	☐	☐	____/____/_____	
c. HBeAg	☐	☐	☐	____/____/_____	
d. anti-HBe	☐	☐	☐	____/____/_____	
e. Other: _____	☐	☐	☐	____/____/_____	
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** 1☐U.S.A. 2☐ Other, Specify: _____ 9☐ 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

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. __-__-__-___

Infant(s)

☐ New Report ☐ Update ☐ False Positive ☐ Closed

☐ Transfer (specify TO and FROM below)

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

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

Birth Information:

3. **Source of payment for delivery? (Check all that apply)**
1☐ Medi-Cal 4☐ Self-pay
2☐ Other/Govt. 3rd party payer 5☐ Low income: _____
3☐ Private 3rd party payer 9☐ Other/Unk: _____

4**. Delivery hospital:**

Name: _____

City: _____

5. **Pediatric Care Provider:**

Name:_____

Clinic Name**:** _____

City**:** _____ Phone:_____

Infant's MRN: _____ Case ID:_____

Infant Information:

Infant # ___ If only one live infant, enter "1". If two or more live infants, attach additional page for each infant, assign the same case/ household ID number on this form, number each infant accordingly (1, 2, 3 etc.) and complete the infant section only.

6. **Name:** _____ (Last / First / MI)

7a. **Birth date:** ___/___/_____ (mm / dd / yyyy)

8. **Sex:** 1☐Male 2☐Female

7b. **Time of Birth (military):** ___:___ (hh:mm)

Immunization Record:

9. **HBIG** a. ☐ Not given b. ☐ Given

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

d. **If date/time not available, age in hrs when given** _____

10. **Hep B Vac1** a. ☐ Not given b. ☐ Given

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

d. **If date/time not available, age in hrs when given** _____

11. **Hep B Vac2** a. **Date when given** ___/___/_____ (mm / dd / yyyy)

b. **Type of vaccine (if known):** _____

12. **Hep B Vac3** **a. Date when given** ___/___/_____ (mm / dd / yyyy)

b. **Type of vaccine (if known):** _____

13. **Hep B Vac4** (If applicable) a. **Date when given** ___/___/_____ (mm / dd / yyyy)

b. **Type of vaccine (if known):** _____

Post-Vaccination Follow-up Serology Record:

14. a. **HBsAg test done?** 1☐Yes 2☐No 9☐Unknown

If 'Yes': b. Date done _____/_____/_____ (mm / dd / yyyy)

c. Result: 1☐Pos 2☐Neg 9☐Unknown

15. a. **Anti-HBs test done?** 1☐Yes 2☐No 9☐Unknown

If 'Yes': b. Date done _____/_____/_____ (mm / dd / yyyy)

c. Result: 1☐Pos 2☐Neg 9☐Unknown

16. **Reasons PVST was not completed** (select all that apply)**:**

☐ Compliance problem with physician/hospital
☐ Funding problem (i.e, lack of insurance, incomplete reimbursement)*
☐ Social circumstances/Access to Care
☐ Parent declined PVST
☐ Parent concern over blood draw
☐ Other (specify):_____

**If a parent expresses concern regarding the cost of PVS testing, please contact CDPH PHPP and ask about the Quest Lab No-Cost Screening Contract*

THE FOLLOWING SHOULD BE SENT TO CDPH PHPP IMMEDIATELY:

PEP Errors: If infant has PEP error, complete page 4 of this form and fax to CDPH ASAP.

Out-of-State Transfer: Complete Out-of-State Transfer Form and submit to CDPH immediately.

Infected Infants: If infant is found to be infected at post-vaccination serology, complete Perinatal Case Report form (CDPH 8702 http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph8702.pdf) and fax this page to CDPH ASAP.

(Please see following page for second immunization series and repeat post-serology record)

California Perinatal Hepatitis B Prevention Program

Case/Household Identification No. ___-___-___-____
County mm yy

Name: _____ **Birth date:** ___/___/_____
Last First MI 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:**_____

Post-Exposure Prophylaxis (PEP) Errors

A PEP error has occurred when an infant born to an HBsAg positive mother does not receive HBIG and/or HBV vaccine at all OR within the recommended time frame (within 12 hours of birth). ***If a PEP error occurs, please complete the following form and fax to (510) 620-3949 within 5 business days***

☐ New Report **County:** _____ **PHPP ID Number** ___ ___ ___ ____
☐ Update

MOTHER'S Name: **MOTHER'S date of birth**

_____ ___ ___ ____
Last First MI mm dd yyyy

INFANT'S Name: **INFANT'S date of birth** **Time of birth**

_____ ___ ___ ____ ____ ____
Last First MI mm dd yyyy (Military Time: hh:mm)

Sex: 1☐Male 2☐Female

Hospital Name: _____ **Phone:** _____ **Fax:** _____

HBIG ☐ Not given ☐ Given **Hep B Vac1** ☐ Not given ☐ Given

Date and time when given ___ ___ ____ ____ ____ **Date and time when given** ___ ___ ____ ____ ____
mm dd yyyy (military, hh:mm) mm dd yyyy (military, hh:mm)

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

Reasons for error (check all that apply)

HBsAg testing

☐ Mother's status was not known at the time of admission
- ☐ Hospital did not test mother
- ☐ Hospital tested mother but the results were delayed

☐ Mother's HBsAg status was misinterpreted
- ☐ By a clinician at the hospital
- ☐ By the treating provider who provided incorrect information to the hospital

☐ Original lab result was not available in the hospital record
- ☐ Mother's HBsAg result was communicated verbally to the hospital
- ☐ Mother's HBsAg result was communicated in writing to the hospital

☐ Mother had multiple HBsAg tests and hospital only had documentation of a negative test

☐ Hospital did not assess mother's HBsAg status

PEP Availability

☐ Pharmacy was closed/delay in the pharmacy
☐ Pharmacy did not have HBIG in stock
☐ Pharmacy did not have HBV vaccine in stock

Compliance

☐ Parent refused PEP for infant
☐ Physician did not provide PEP to infant
☐ Parent did not present child to care for PEP (e.g. in the event of a home birth where the infant might receive PEP in an ED or other planned facility)

Patient Care

☐ Staff miscommunication or poor recordkeeping of administration/receipt of PEP
☐ Short-staffed; patient census high; could not provide PEP within time frame
☐ Change of shift

Infant Medical Reason

☐ Infant medical emergency
☐ Physician or other clinician refused to provide PEP to infant because of infant's medical condition

☐ Other (if so, please specify) _____

PLEASE SUBMIT ANY INFANT UPDATES AND POST-VACCINATION SEROLOGIC TESTING RESULTS USING FORM CDPH 8546

Please describe why the PEP error occurred in as much detail as possible. Attach any lab reports and relevant medical records available for this mother and infant.

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

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