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| **PART 1: MATERNAL** | | | | | |
| Name  ADDRESS  DATE OF HBsAg TESTING  HBsAg TEST RESULT  MD  MD PHONE NUMBER | DOB  ETHNICITY  COUNTY  STATE  PHONE( H)  PHONE (C)  PHONE (W) | | | | EDC  BIRTHING HOSPITAL  PHONE NUMBER  MOTHER’S INSURANCE TYPE  LANGUAGE SPOKEN |
| PART 2: HOUSEHOLD/SEXUAL CONTACTS | | PART 3: INFANT | | | |
| # OF HOUSEHOLD CONTACTS:  # RECEIVING PREVACCINATION SEROLOGIC  TESTING  # HBsAg (+) # IMMUNE TO HBV  #SUSCEPTIBLE #VACCINATED THIS PREGNANCY | | | NAME DOB WEIGHT  ADDRESS:  COUNTY  STATE  MD FOR VACCINATIONS/ PHONE NUMBER | | |
| Part 4: INFANT’S VACCINATIONS/ POSTVACCINATION SEROLOGY RESULTS | | | | | |
| DATE OF HBIG  DATE OF HEPATITIS VACCINE/BRAND   |  |  | | --- | --- | | HepB #1 | HepB #4 (if needed) | | HepB #2 | HepB #5 (if needed) | | HepB #3 | HepB #6 (if needed) | | | | | HEPATITIS B SURFACE ANTIGEN (HBsAg)  ANTIBODY TO HEPATITIS B SURFACE ANTIGEN  (Anti-HBs) – QUANTITATIVE  REPEATED RESULTS, IF NEEDED  HBsAg Anti-HBs | |
| PART 5 CASE NOTES | | | | | |
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