|  |
| --- |
| **PART 1: MATERNAL** |
| Name ADDRESSDATE OF HBsAg TESTINGHBsAg TEST RESULTMDMD PHONE NUMBER  | DOBETHNICITY COUNTYSTATEPHONE( H)PHONE (C)PHONE (W) | EDCBIRTHING HOSPITAL PHONE NUMBERMOTHER’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 WEIGHTADDRESS: COUNTYSTATEMD 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 NEEDEDHBsAg Anti-HBs |
| PART 5 CASE NOTES |
|   |