



Washington State Immunization Program
P.O. Box 47843 • Olympia, WA 98504-7843

PERINATAL HEPATITIS B CONFIDENTIAL CASE REPORT - HOUSEHOLD CONTACT

Please complete all sections of this form. See detailed instructions on back.

Section I: Contact's Information

CONTACT'S NAME LAST FIRST MIDDLE				SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown	CONTACT'S DATE OF BIRTH
ADDRESS STREET					CONTACT'S TELEPHONE ()
CITY	STATE	ZIP	COUNTY		
HOUSEHOLD CONTACT'S RACE <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)					
RELATION OF CONTACT TO MOTHER <input type="checkbox"/> Husband/Partner <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Family Member <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
CONTACT'S CARE PROVIDER: NAME					PROVIDER'S TELEPHONE ()
STREET ADDRESS		CITY	STATE	ZIP	COUNTY
CARRIER MOTHER'S NAME LAST FIRST				MOTHER'S DATE OF BIRTH	

Section II: Contact's Pretesting Information

Test	Date	Results	Administered by	Payment Source
HBsAg		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk/Untested	<input type="checkbox"/> Health Dept. <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Other (specify)
Anti-HBs		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk/Untested	<input type="checkbox"/> Health Dept. <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Other (specify)

Section III: Contact's Vaccination Information

Vaccine	Date	Administered by	Payment Source
HBIG		<input type="checkbox"/> Health Dept <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)
Vaccine Dose 1		<input type="checkbox"/> Health Dept <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)
Vaccine Dose 2		<input type="checkbox"/> Health Dept <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)
Vaccine Dose 3		<input type="checkbox"/> Health Dept <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)

Section IV: Sexual Contact's Posttesting Information

Test	Date	Results	Administered by	Payment Source
HBsAg		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk/Untested	<input type="checkbox"/> Health Dept. <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Other (specify)
Anti-HBs		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk/Untested	<input type="checkbox"/> Health Dept. <input type="checkbox"/> Unknown <input type="checkbox"/> Private Provider <input type="checkbox"/> Other	<input type="checkbox"/> Insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Other (specify)

Section V

Case Closed	<input type="checkbox"/> Moved <input type="checkbox"/> Can't Locate <input type="checkbox"/> Refuses Follow up <input type="checkbox"/> Other (specify)
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Section VI

MOTHER'S ID	CHILD'S ID	REPORT DATE
REPORTED BY NAME	PHONE	COUNTY

**INSTRUCTIONS FOR COMPLETING PERINATAL HEPATITIS B
CONFIDENTIAL CASE REPORT
HOUSEHOLD CONTACT**

1. Complete a case report form **only** for household contacts of pregnant women who are HBsAg-positive during their pregnancy.
2. Complete the contact's information section, the **screening** information and the information about hepatitis B vaccine **Dose #1** as soon as the information is known. Keep the original case report form for your files and send a copy of the case report form to the Immunization Program.
3. Complete the information on hepatitis B vaccine **Dose #2** as soon as the information is known. Keep the original case report form for your files and send a copy of the updated case report form to the Immunization Program.
4. Complete the information on hepatitis B vaccine **Dose #3** as soon as the information is known. Keep the original case report form for your files and send a copy of the updated case report form to the Immunization Program.
5. Complete the information on **posttesting** for **sexual contacts** as soon as the information is known. Keep the original case report form for your files and send a copy of the updated case report form to the Immunization Program.

Summary: Forms should be completed and copies sent to the Immunization Program at the following times:

1. After pretesting and/or after vaccination with HBIG and/or Dose #1
2. After vaccination with Dose #2
3. After vaccination with Dose #3
4. After posttesting for sexual contacts
5. After the household contact case is closed

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