



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

PERINATAL HEPATITIS B CONFIDENTIAL CASE REPORT - MOTHER/INFANT

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

Section I: Mother's Information					
MOTHER'S NAME LAST FIRST MAIDEN			MOTHER'S DATE OF BIRTH		
ADDRESS STREET			MOTHER'S HOME TELEPHONE ()		
CITY		STATE	ZIP	COUNTY	
			WORK OR MESSAGE TELEPHONE ()		
MOTHER'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)					
EDC (DATE)		DELIVERY HOSPITAL			
MOTHER'S HEALTH CARE PROVIDER NAME (OPTIONAL)				PROVIDER'S TELEPHONE (OPTIONAL) ()	
PROVIDER'S STREET ADDRESS (OPTIONAL)		CITY	STATE	ZIP	COUNTY
DATE OF POSITIVE HBSAG TEST	ADMINISTERED BY	PAYMENT SOURCE			
	<input type="checkbox"/> Health Dept. <input type="checkbox"/> Hospital <input type="checkbox"/> Private Provider <input type="checkbox"/> Unknown <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 II: Infant's Information					
INFANT'S NAME LAST FIRST MIDDLE INITIAL		SEX	DATE OF BIRTH		
		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown			
INFANT'S HEALTH CARE PROVIDER NAME (OPTIONAL)				PROVIDER'S TELEPHONE (OPTIONAL) ()	
PROVIDER'S STREET ADDRESS (OPTIONAL)		CITY	STATE	ZIP	COUNTY

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

Section III: Follow Up Serology (3-9 Months After Dose 3)				
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"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> Private Provider	<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"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> Private Provider	<input type="checkbox"/> Insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Other (specify)

Section IV				
Case Closed		<input type="checkbox"/> Moved <input type="checkbox"/> Can't Locate <input type="checkbox"/> Refuses Follow up <input type="checkbox"/> False Positive <input type="checkbox"/> Pregnancy Ended <input type="checkbox"/> Other (specify)		

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

**INSTRUCTIONS FOR COMPLETING PERINATAL HEPATITIS B
CONFIDENTIAL CASE REPORT
MOTHER/INFANT**

1. Complete a case report form **only** for pregnant women who are HBsAg-positive during their pregnancy and infants born to HBsAg-positive women.
2. Complete the mother's information section as soon as the **HBsAg-positive test result** is known. Keep the original case report for your files and send a copy of the case report to the Immunization Program.
3. Using the same case report as the mother's, complete the infant's information section, including the information on **HBIG** and hepatitis B vaccine **Dose #1** as soon as the infant is born. Keep the original case report for your files and send a copy of the updated case report to the Immunization Program.
4. Complete the information on hepatitis B vaccine **Dose #2** as soon as the information is known. Keep the original case report for your files and send a copy of the updated case report to the Immunization Program.
5. Complete the information on hepatitis B vaccine **Dose #3** as soon as the information is known. Keep the original case report for your files and send a copy of the updated case report to the Immunization Program.
6. Complete the **follow-up serology** information as soon as the results are known. Keep the completed original case report for your files and send a copy of the completed case report to the Immunization Program.

Summary: One form should be completed for one mother and her infant with each pregnancy. The forms should be completed and copies sent to the Immunization Program at the following times:

1. After HBsAg-positive test on mother
2. After birth of infant and vaccination with HBIG and Dose #1
3. After vaccination with Dose #2
4. After vaccination with Dose #3
5. After follow-up serology
6. After mother/infant case is closed

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