**Perinatal Hepatitis B Case and Contact Report**

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| **Lab/Facility Reporting HBsAg+Test:** | **Report Date:** |
| **State Health Center/Health Department:** | **District:** |
| **Assigned to:** | **Phone:** |

**Section I: Data on Prenatal Woman**

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| **Last Name:** | **First Name: MI:** |
| **Address:** | **Phone:** |
| **City:** | **State: Zip Code:** |
| **Date of Birth:** | **County:** |

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| **Ethnicity: Hispanic □ non-Hispanic □ PA-NEDSS#:**  **Race: White □ Black □ Asian/Pacific Islander □ American Indian/Alaska Native □** |
| **Insurance: Medicaid Private Uninsured** |

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| **Date of HBsAg + test: EDC:** |
| **Delivery Hospital: Phone:** |
| **Maternal Care Provider: Phone:** |

**Section II: Data on Household/Sexual Contact(s)**

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| --- | --- | --- | --- | --- | --- |
| **Name** | **HBsAg test results** | **Anti-HB test results** | **HB1** | **HB2** | **HB3** |
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| **If contacts immunized as result of this case indicate name/dates/doses:** | | | | | |
|  | | | | | |

**Section III: Data on Newborn**

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| --- | --- |
| **Pregnancy Outcome: a. # of live births:** | **b. pregnancy terminated: Yes □ No □** |

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| **Infant Last Name:** | **Infant First Name:** | |
| **Sex: Male □ Female □** | **DOB:** | **Weight (g):** |

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| **Ethnicity: Hispanic □ non-Hispanic □ PA-NEDSS#:** |
| **Race: White □ Black □ Asian/Pacific Islander □ American Indian/Alaska Native □** |

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| --- | --- | --- | --- |
| **Date:** | **Vaccine:** | **Insurance:** | **Primary Care Provider:** |
| **HBIG** |  |  |
| **HBV1** |  |  | **Serology at 9 months**  **Date:**  **HBsAg: Positive □ Negative □**  **Ant-HBs: Positive □ Negative □** |
| **HBV2** |  |  |
| **HBV3** |  |  |
| **HBV4** |  |  |
| **Comments: Vaccine used: HyperHep B; Engerix B; Recombivax-HB; Pediarix; Comvax** | | | |
| **Comments: Insurance: Private; Medicaid; Uninsured** | | | |

**Section VI: Case Outcome**

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| **Case Transferred: □** | **Transferred to:** |
| **Lost to follow-up: □ Can’t locate: □ Refused follow-up: □ Other:** | |
| **Comments:** | |
|  | |

**Instructions for Completing the Perinatal Hepatitis Case and Contact Report**

The Perinatal Hepatitis B Case and Contact Report is to be completed on all pregnant women who test positive for hepatitis B surface antigen (HBsAg), the infants born to them, and their household/sexual contacts.

***Section I:***

When a HBsAg positive test result on a pregnant woman is reported from laboratories, physicians, medical clinics and/or through the electronic disease surveillance system, complete Section I. Department of Health nurses and County/Municipal Health Departments are to complete this section and fax, mail, or send by secure email to the Department of Immunizations, Perinatal Hepatitis B Coordinator.

***Section II: Data on Contact(s)***

Identify each household/sexual contact of the prenatal case. Indicate the results of previous serology if known and the number of hepatitis B vaccines doses received. Refer non-immunized contacts for testing and document the number of hepatitis B immunizations given as a result of this case.

***Section III: Data on Newborn***

For multiple births, complete a separate form for each newborn.

***Note:***

Please complete all fields. Information on ethnicity and race of the mother and baby, as well as serology results and hepatitis B immunizations given to contacts as a result of the case are reported yearly to the Centers for Disease Control and Surveillance (CDC).

Please report all cases moving out of state to the Perinatal Hepatitis B Coordinator who will transfer theses cases. Transfers within the state are to be done by the district nurses.

Please refer to “Guidelines for District Offices/SHC/County/Municipal Health Departments” for case management.

***Definitions:***

EDC Expected date of confinement (delivery date or due date)

Pregnancy Terminated: Pregnancy results in abortion, miscarriage or stillbirth

Serologic Screening: HBsAg (Hepatitis B surface antigen)

Anti-HBs (Hepatitis B surface antibody)

HBV Hepatitis B Vaccine

HBIG Hepatitis B Immune Globulin