

# California Perinatal Hepatitis B Prevention Program Confidential HBsAg+ Case/Household Management Report

Mail to: Perinatal Hepatitis B Prevention Program  
Immunization Branch  
California Department of Public Health  
850 Marina Bay Parkway  
Building P, 2<sup>nd</sup> Floor  
Richmond, CA 94804  
OR Fax to: (510) 620-3949

- New Report     Update     False Positive     In-State Transfer
- Infected Infant     PEP Error     Closed     Out-of-State Transfer to state: \_\_\_\_\_

**(For Infected Infants, PEP Errors & Out of State Transfers, fax report to State PHPP ASAP)**

## Pregnant HBsAg+ Mother

1. Case/Household Identification No. \_\_\_\_\_  
County mm yy

2. County: \_\_\_\_\_ 3. Date this report initiated \_\_\_\_/\_\_\_\_/\_\_\_\_ 4. SSN \_\_\_\_\_  
if available

5. Name: \_\_\_\_\_  
Last First MI

6. Mother's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ 7. Mother's age when screened \_\_\_\_\_ 8. EDD \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy mm dd yyyy

9. City \_\_\_\_\_ 10. Zip \_\_\_\_\_

11a. Was this case transferred from another county? 11b. If yes, what was that county's ID number:  
1  Yes 2  No 9  Unknown \_\_\_\_\_  
County mm yy

12. Is this the first case/household management report submitted to CA Perinatal Hep. B Prog. on this mother?  
1  Yes 2  No (include previous ID number: \_\_\_\_-\_\_\_\_-\_\_\_\_) 9  Unknown

13. Source of HBsAg+ report (check all that apply)  
1  Laboratory 2  Prenatal care provider 3  Delivery hospital 9  Unknown  
4  Other (Specify): \_\_\_\_\_

14a. Was HBsAg+ known before this pregnancy? 14b. If "Yes", was this discovered in connection with a previous pregnancy?  
1  Yes 2  No 9  Unknown 1  Yes 2  No 9  Unknown

15. Diagnostic tests	Positive	Negative	Unknown	Date of test (MM/DD/YYYY)	Comments
a. HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
b. HBeAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
c. anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
d. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	_____
e. HBV DNA (describe results) _____				____/____/____	_____

16a. Planned delivery hospital? Name: \_\_\_\_\_ City: \_\_\_\_\_  
16b. If mother is a Kaiser patient, include Kaiser Medical Record Number: \_\_\_\_\_ Case ID Number: \_\_\_\_\_  
(for Northern CA Kaiser Perinatal Program)

17. Country of mother's birth 1  U.S.A. 2  Other, Specify: \_\_\_\_\_ 9  Unknown

<p>18a. Race: (Check all that apply)</p> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian/ Alaskan Native <input type="checkbox"/> Other/Unspecified	<p>Asian (check all that apply)</p> <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Filipino <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian (non-Hmong)	<input type="checkbox"/> Thai <input type="checkbox"/> Laotian (non-Hmong) <input type="checkbox"/> Vietnamese (non-Hmong) <input type="checkbox"/> Hmong <input type="checkbox"/> Mien <input type="checkbox"/> Other Asian: _____	<p>Pacific Islander (check all that apply)</p> <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Tongan <input type="checkbox"/> Other Pacific Islander: _____
<p>18b. Ethnicity:</p> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			

19. Initial submit date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 20. Close date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy mm dd yyyy

Person completing form: \_\_\_\_\_ Date: \_\_\_\_\_  
Agency: \_\_\_\_\_ Phone: \_\_\_\_\_



# California Perinatal Hepatitis B Prevention Program Confidential HBsAg+ Case/Household Management Report

Case/Household Identification No. \_\_\_\_\_  
County mm yy

Name: \_\_\_\_\_  
Last First MI

Birth date: \_\_\_\_\_  
mm dd yyyy

### Second Series Immunization and Repeat Post-Vaccination Serology Record:

16. a. If 'Neg', did infant receive a 2<sup>nd</sup> series of vaccine?  
1  Yes 2  No 9  Unknown

17. a. Was HBsAg test done after 2<sup>nd</sup> series?  
1  Yes 2  No 9  Unknown

b. Hep B Vac1 \_\_\_\_\_  
mm dd yyyy

b. Date done \_\_\_\_\_  
mm dd yyyy

c. Hep B Vac2 \_\_\_\_\_  
mm dd yyyy

c. Result: 1  Pos 2  Neg 9  Unknown

d. Hep B Vac3 \_\_\_\_\_  
mm dd yyyy

18. a. Was Anti-HBs test done after 2<sup>nd</sup> series?  
1  Yes 2  No 9  Unk

b. Date done \_\_\_\_\_  
mm dd yyyy

c. Result: 1  Pos 2  Neg 9  Unknown

### Lost to Follow-up (for mother and infant):

- 19a. Lost  before infant was born
- during vaccination series
- before PVS testing completed

19b. Check all reasons mother and infant were lost to follow up (check all that apply)

- Hospital birth records available, but infant could never be located
- Infant moved or transferred to another county within the state for follow-up
- Infant moved out of the state :  new address: \_\_\_\_\_  
 no forwarding address available
- Infant moved out of the country
- Compliance problem with family (i.e, uncooperative, refused PEP)
- Infant died – date of death: \_\_\_\_\_, time of death (if available) \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Physician did not order post-vaccination serological testing
- Funding problem (i.e, lack of insurance, incomplete reimbursement)

***If needed, please use this space to explain why mother and/or infant were lost to follow-up:***

***Other Remarks:***

NOTE: If further comments are necessary, please attach a separate page with additional information

Person completing form: \_\_\_\_\_ Date: \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_



# California Perinatal Hepatitis B Prevention Program Confidential HBsAg+ Case/Household Management Report

## Household Contacts

1. Case/Household Identification No. \_\_\_\_\_  
County    mm    yy

### 2. All Household Contacts

- a. \_\_\_\_\_ Total number of household contacts identified (a = b+c+d+j+k)
- b. \_\_\_\_\_ Number already known to be chronically infected or immune due to prior infection of Hep B
- c. \_\_\_\_\_ Number previously immunized
- d. \_\_\_\_\_ Number seroscreened for Hep B markers (usually anti-HBc)
  - e. \_\_\_\_\_ Of those seroscreened, number age ≤ 5 years
  - f. \_\_\_\_\_ Of those seroscreened, number age ≥ 6 years
  - g. \_\_\_\_\_ Of those seroscreened, number found to be already infected or immune
  - h. \_\_\_\_\_ Of those seroscreened, number found to be susceptible (i.e. negative for Hep B markers)
    - i. \_\_\_\_\_ Of those found to be susceptible, number vaccinated
- j. \_\_\_\_\_ Number vaccinated without screening
- k. \_\_\_\_\_ Number lost to follow-up

### 3. Household Contacts Receiving Immunization (list in any order)

Please enter the codes in ( ) into the spaces below.

	a.	b.	c.	d.	e.
	Name (optional)	Age: 0-5 yrs (1); 6-21 yrs (2); >22 yrs. (3)	Hep B Vac 1 given? Yes (1); No (2); Unk (9)	Hep B Vac 2 given? Yes (1); No (2); Unk (9)	Hep B Vac 3 given? Yes (1); No (2); Unk (9)
Contact 1					
Contact 2					
Contact 3					
Contact 4					
Contact 5					
Contact 6					

### 4. Lost to Follow-Up

If any of the household contacts listed above does not complete the 3-dose series, check all of the reasons that apply.

- a.  Contact(s) located but later lost to follow-up
- b.  Contact(s) found to be already infected or immune after series was started
- c.  Contact(s) moved to another county within the state for follow-up and don't know whether vaccination series was completed or not
- d.  Contact(s) moved out of the state
- e.  Contact(s) moved out of the country
- f.  Contact(s) died
- g.  Compliance problem with family
- h.  Other (specify): \_\_\_\_\_

Person completing form: \_\_\_\_\_

Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone: \_\_\_\_\_

# California Perinatal Hepatitis B Prevention Program

## Confidential HBsAg+ Case/Household Management Report

Case/Household Identification No. \_\_\_\_\_  
County    mm    yy

**Optional worksheet (Do not send to State)**

Name \_\_\_\_\_

Household address(es)/phone(s) \_\_\_\_\_

Translator needed?     YES     NO                      Mother's language \_\_\_\_\_

Staff person assigned to case/household \_\_\_\_\_ Delivery hospital \_\_\_\_\_

Provider type \_\_\_\_\_    Provider type \_\_\_\_\_

Physician name \_\_\_\_\_    Physician name \_\_\_\_\_

Clinic address(es) \_\_\_\_\_    Clinic address(es) \_\_\_\_\_

Phone(s) \_\_\_\_\_    Phone(s) \_\_\_\_\_

**Infant(s)**                      Dates Doses Due/Given= 

Due
Given

Name(s)	Date of Birth	HBIG/Vac #1	Vac #2	Vac #3	Vac 4	PVS*
1.						
2.						

\*Post Vaccination Serology Testing

**Household Contacts**                      Dates Doses Due/Given= 

Due
Given

Name(s)	DOB	Sex	Date Referred	Serology Results	Vac #1	Vac #2	Vac #3	Notes
1.								
2.								
3.								
4.								
5.								
6.								

# California Perinatal Hepatitis B Prevention Program Confidential HBsAg+ Case/Household Management Report

- New Report       Update       False Positive       In-State Transfer  
 Infected Infant     PEP Error     Closed       Out-of-State Transfer - to state: \_\_\_\_\_

**(For Infected Infants, PEP Errors & Out of State Transfers, fax report to State PHPP ASAP)**

## Infant(s)

2a. Was this case transferred from another county?  
1  Yes    2  No    9  Unknown

3. This pregnancy resulted in a: (Check all that apply)  
a. Live birth: Number of live infant(s) born: \_\_\_\_\_  
b. Fetal death: Number of fetal deaths: \_\_\_\_\_  
c. Miscarriage or abortion:  (check box if 'yes')

4. Source of payment for delivery?  
(Check all that apply)  
1  Medi-Cal                      4  Self-pay  
2  Other/Govt. 3<sup>rd</sup> party payer    5  Low income: \_\_\_\_\_  
3  Private 3<sup>rd</sup> party payer      9  Other/Unk: \_\_\_\_\_

1. Case/Household Identification No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
County    mm    yy

2b. If yes, what was that county's ID number:  
\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
County    mm    yy

5a. Delivery hospital – Same as planned delivery hospital?  
1  Yes    2  No    9  Unknown

5b. If "No", enter actual delivery hospital:  
Name: \_\_\_\_\_  
City: \_\_\_\_\_

5c. If mother or infant are Kaiser patients, include  
Kaiser Medical Record Number: \_\_\_\_\_  
Case ID Number: \_\_\_\_\_  
(for Northern CA Kaiser Perinatal Program)

Infant # \_\_\_\_ If only one live infant, enter "1". If two or more live infants, attach additional page for each infant, assign the same case/household ID number on this form, number each infant accordingly (1, 2, 3 etc.) and complete the infant section only.

6. Name: \_\_\_\_\_ 7a. Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI mm dd yyyy

8. Sex: 1  Male    2  Female      7b. Time of Birth (military): \_\_\_\_:\_\_\_\_ (hh:mm)

### Immunization Record

9. HBIG    a.  Not given    b.  Given  
c. Date and time when given \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_:\_\_\_\_  
mm dd yyyy (military, hh:mm)  
d. If date/time not available, age in hrs when given \_\_\_\_\_  
10. Hep B Vac1    a.  Not given    b.  Given  
c. Date and time when given \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_:\_\_\_\_  
mm dd yyyy (military, hh:mm)  
d. If date/time not available, age in hrs when given \_\_\_\_\_

11. Hep B Vac2    a. Date when given \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy  
b. Type of vaccine (if known): \_\_\_\_\_  
12. Hep B Vac3    a. Date when given \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy  
b. Type of vaccine (if known): \_\_\_\_\_  
13. Hep B Vac4    a. Date when given \_\_\_\_/\_\_\_\_/\_\_\_\_  
(If applicable) mm dd yyyy  
b. Type of vaccine (if known): \_\_\_\_\_

### Post-Vaccination Follow-up Serology Record:

14. a. HBsAg test done? 1  Yes 2  No 9  Unknown  
If 'Yes': b. Date done \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy  
c. Result: 1  Pos 2  Neg 9  Unknown  
15. a. Anti-HBs test done? 1  Yes 2  No 9  Unknown  
If 'Yes': b. Date done \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy  
c. Result: 1  Pos 2  Neg 9  Unknown

**PEP Errors** If infant has PEP error, complete page 4 of this form and fax to IZB ASAP.  
**Infected Infants:** If infant is found to be infected at post-vaccination serology, complete Perinatal Case Report form (CDPH 8702 <http://www.cdph.ca.gov/pubsforms/forms/CtrIdForms/cdph8702.pdf>) and fax this page to IZB ASAP.

(Please see following page for second series immunization and repeat post-serology record)



