



Hepatitis B Perinatal Case Report – Infant/Contact

Please complete this form each time you administer a dose of hepatitis B vaccine and/or hepatitis B immune globulin (HBIG) to an infant whose mother has tested HBsAg-positive or to her household or sexual contacts. **Mail** this form to MDCH, Immunization Division, PO Box 30195, Lansing, MI 48909; or **fax** 517-335-9855; or **call** 517-335-8122 or 1-800-964-4487. In **southeast Michigan**, **mail** to MDCH, Immunization Division, Detroit Regional Office, 3056 W. Grand Blvd., Suite 3-220, Detroit, MI 48202; or **fax** 313-456-0639; or **call** 313-456-4432 or 313-456-4431. Also, please make sure to update the infant/contact's MCIR record.

PROVIDER										
Hospital or Provider Name								County		
Address										
City				Zip Code			Telephone #			
HBsAg POSITIVE MOTHER										
Mother's Name					Medical Record #			Date of Birth / /		
Address							City		Zip Code	
Mom's Insurance <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown				Telephone #			Emergency Contact Name & Telephone #			
Grav	Para		Country of Birth			Maternal Grandma's Country of Birth				
TEST DATE RESULTS: (P=POSITIVE/REACTIVE N=NEGATIVE/NON-REACTIVE U=UNKNOWN)										
HBsAg / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		HBsAg / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		HBsAg / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		HBsAg / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		HBsAg / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		
HBV DNA / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		Anti-HBc / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		Anti-HBc / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		Anti-HBc IgM / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		Anti-HBc IgM / / <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U		
Genotype		HBV Viral Load			Other infections <input type="checkbox"/> HCV <input type="checkbox"/> HIV <input type="checkbox"/> Other (please specify)					
Race	<input type="checkbox"/> Asian/PI		<input type="checkbox"/> Black		<input type="checkbox"/> White		<input type="checkbox"/> American Indian		<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Unknown
Ethnicity	<input type="checkbox"/> Hispanic			<input type="checkbox"/> Other (please specify)			<input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> Unknown	
Mother need an interpreter? <input type="checkbox"/> Y <input type="checkbox"/> N			If yes, what language?				Mother referred for care/evaluation for hepB? <input type="checkbox"/> Y <input type="checkbox"/> N			
Mother being treated for hepB? <input type="checkbox"/> Y <input type="checkbox"/> N			If yes, treatment start date / /			Treatment brand/dose				
INFANT OR HOUSEHOLD/SEXUAL CONTACT										
Name						DOB / /		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth Weight (If infant)			Time of Birth (If infant)			<input type="checkbox"/> AM <input type="checkbox"/> PM		Medical Record #		
Infant's Insurance <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown										
VACCINE/LAB RESULTS OF INFANT OR CONTACT										
Vaccine	Date Given	Time Given (if infant)	Manufacturer	Lab Results	Test Date					
HBIG	/ /	<input type="checkbox"/> AM <input type="checkbox"/> PM		HBsAg	/ /					
Hep B #1	/ /	<input type="checkbox"/> AM <input type="checkbox"/> PM		Anti-HBs	/ /					
Hep B #2	/ /			Anti-HBc IgM	/ /					
Hep B #3	/ /			Anti-HBc	/ /					
FOLLOW-UP CARE PROVIDER OF INFANT OR CONTACT (if different from above)										
Facility's Name					Provider's Name					
Address					City			Zip Code		
Telephone #					County					
Name of Person Completing This Form					Telephone #					