



# Hepatitis B Perinatal Case Report – Infant/Contact

Michigan Department of Community Health (MDCH)

Please complete this form each time a dose of hepatitis B vaccine and/or hepatitis B immune globulin (HBIG) is administered to an infant whose mother has tested hepatitis B surface antigen (HBsAg) positive or when given to her household or sexual contacts. **Mail** this form to MDCH, Immunization Division, PO Box 30195, Lansing, MI 48909; or **fax** to 517-335-9855; or **call** the Perinatal Hepatitis B Prevention staff at 517-335-8122 or 1-800-964-4487. In **southeast Michigan, mail** to MDCH, Immunization Division, Detroit Regional Office, 3056 W. Grand Blvd., Suite 3-150, Detroit, MI 48202; or **fax** to 313-456-4427; or **call** 313-456-4431 or 313-456-4432. Also, please make sure to update the infant/contact's Michigan Care Improvement Registry (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
Social Security #			Telephone #		Emergency Contact Name & Telephone #	
Grav	Para	Country of Birth			Maternal Grandmother'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	HBeAg	/ /
		<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> U	HBeAb	/ /
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 IgM	/ /
HBV Viral Load		Other infections (HCV, HIV, other STIs, etc)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	If yes, 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		
Does mother need an interpreter?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, what language?	Repeat HBsAg	/ /	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U
Was mother referred for care/evaluation for hepatitis B infection?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Is mother being treated for hepatitis B infection?	<input type="checkbox"/> Y	<input type="checkbox"/> N	
If yes, treatment start date	/ /	Treatment brand/dose				
INFANT OR HOUSEHOLD/SEXUAL CONTACT (relationship of 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 #
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 #			

Patients may NOT be charged for cost of vaccines provided through project grant funds whether administered in public clinics or by private physicians. Vaccine may NOT BE DENIED in public clinics for failure to pay administration fee or to make a donation to the provider.