# 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 MDHHS, Immunization Division, PO Box 30195, Lansing, MI 48909; or **fax** it to 517-335-9855; or **call** 517-284-4893, 517-284-4885 or 517-335-9443. 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**

| Mom's Name | Medical Record # | Date of Birth / / |
|---|---|---|
| Address | City | Zip Code |
| Telephone # | Emergency Contact Name & Telephone # | Grav / Para |

Race ❒ Asian/PI ❒ Black ❒ White ❒ American Indian ❒ Alaska Native ❒ Other _____ ❒ Unknown

Ethnicity ❒ Hispanic ❒ Non-Hispanic ❒ Unknown | Method of Delivery ❒ Vaginal ❒ Cesarean

Mom's Country of Birth | Interpreter Needed? ❒ Y ❒ N

If yes, What Language? | Name of Mom's Physician/Telephone #

Mom's Insurance ❒ Private ❒ Medicaid ❒ Uninsured ❒ County Health Plan ❒ Medicare ❒ Military (Tricare) ❒ Unknown

**TEST DATE and RESULTS (P=Positive/Reactive N=Negative/Non-Reactive U=Unknown); Other Infections; Immunizations**

| HBsAg | / / | ❒ P ❒ N ❒ U | Repeat HBsAg | / / | ❒ P ❒ N ❒ U |
|---|---|---|---|---|---|

Other Infections ❒HCV ❒HIV ❒Syphilis ❒Other (please specify) _____

Did Mom Receive Tdap ***(this pregnancy)*** Y N Date ___/___/___ Flu ***(this pregnancy)*** Y N Date ___/___/___ Doses in MCIR Y N

**INFANT or HOUSEHOLD/SEXUAL CONTACT**

| Name | DOB / / | Sex ❒ Male ❒ Female |
|---|---|---|
| Birth Weight (If infant) | Time of Birth (If infant) ___ : ___ ❒ AM ❒ PM | Medical Record # |

Infant's Insurance ❒ Private ❒ Medicaid ❒ Uninsured ❒ County Health Plan ❒ Medicare ❒ Military (Tricare) ❒ Unknown

**VACCINE/LAB RESULTS of INFANT or CONTACT**

| Vaccine | Date Given | Time Given (if infant) | Manufacturer | Lab Results | Test Date |
|---|---|---|---|---|---|
| HBIG | / / | ___ : ___ ❒ AM ❒ PM | | HBsAg | / / |
| Hep B #1 | / / | ___ : ___ ❒ AM ❒ 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 # | |