

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** 517-335-9855; or **call** 517-284-4893 or 1-800-964-4487. In **southeast Michigan**, **mail** to MDHHS, Immunization Division, Detroit Regional Office, 3056 W. Grand Blvd., Suite 3-150, 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						
Mom's Name			Medical Record #		Date of Birth / /	
Address				City	Zip Code	
Telephone #		Emergency Contact Name & Telephone #			Grav	Para
Race <input type="checkbox"/> Asian/PI <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown						
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			Method of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean			
Mom's Country of Birth			Interpreter Needed? <input type="checkbox"/> Y <input type="checkbox"/> N			
If yes, What Language?			Name of Mom's Physician/Telephone #			
Mom's Insurance <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> County Health Plan <input type="checkbox"/> Medicare <input type="checkbox"/> Military (Tricare) <input type="checkbox"/> Unknown						
TEST DATE and RESULTS (P=Positive/Reactive N=Negative/Non-Reactive U=Unknown); Other Infections; Immunizations						
HBsAg	/ /		<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U	Repeat HBsAg	/ /	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U
Other Infections <input type="checkbox"/> HCV <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Other (please specify) _____						
Did Mom Receive Tdap (<i>this pregnancy</i>) <input type="checkbox"/> Y <input type="checkbox"/> N Date ___/___/___ Flu (<i>this pregnancy</i>) <input type="checkbox"/> Y <input type="checkbox"/> N Date ___/___/___ Doses in MCIR <input type="checkbox"/> Y <input type="checkbox"/> N						
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"/> County Health Plan <input type="checkbox"/> Medicare <input type="checkbox"/> Military (Tricare) <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 #			