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 **517-763-0470; or call 517-388-4815, 517-897-3236** or **517-242-8319**. Please make sure to update the infant/contact's MCIR record.

PROVIDER

Hospital or Provider Name			County
Address			
City	Zip Code	Telephone #	Fax #

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 #	Fax #	County	
Name of Person Completing This Form		Telephone #	