Contact Summary Report for Perinatal Hepatitis B Prevention

Contact's Information:

Enrollment Date: ____/____/_____ ID#: ____/____/____/____
mm dd yyyy yr/county/mother/hh#

Last Name: _____First Name: _____ DOB: _____ Sex: M / F

First Name of Index Case: _____Last Name of Index Case:_____

Relationship to Index Case: _____

Address: _____City: _____ Zip: _____County:_____

Home Phone: (___)_____ Work Phone: (___)_____ Medicaid #: _____ SSN:_____

Race/Ethnicity: _____/_____Language Spoken: _____Language Written: _____

Alternate Contact Information:_____

Contact's Provider Information:

Doctor Name: _____ Phone: (___)_____ Fax: (___)_____

Address: _____City: _____ Zip: _____

Contact's Hepatitis B Serology and Vaccine History:

Prior hepatitis B serology test? Yes No

Prior report HBsAg: Pos Neg Date: _____

Prior report anti-HBs: Pos Neg Date: _____

Prior report anti-HBc: Pos Neg Date: _____

Prior Hepatitis B vaccine? Yes No Dates: _____, _____, _____

Results of Serology Tests for the Contact Performed After Enrollment Date:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor /Clinic)
HBsAg				
Anti-HBs				
Anti-HBc				

Hepatitis B Vaccine Record for the Contact – Series 1 Given After Enrollment Date:

Biological	Date	Dose	Formulation	Manufacturer	Lot Number	Provider (Doctor/Clinic)
1st Hep B dose						
2nd Hep B dose						
3rd Hep B dose						

Results of Post Vaccine Serology for the Contact:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
HBsAg				
Anti-HBs				
Anti-HBc				

Hepatitis B Vaccine Record for the Contact – Series 2:

Biological	Date	Dose	Formulation	Manufacturer	Lot Number	Provider (Doctor/Clinic)
4th Hep B dose						
5th Hep B dose						
6th Hep B dose						

Results of Post Vaccine Serology for the Contact – Series 2:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
HBsAg				
Anti-HBs				
Anti-HBc				

Date closed: _____Reason closed: _____ Status: _____