



# Mother Summary Report for Perinatal Hepatitis B Prevention

## Mother's Information:

Enrollment Date: \_\_\_/\_\_\_/\_\_\_ ID#: \_\_\_/\_\_\_/\_\_\_/\_\_\_  
 mm dd yyyy yr/ county/mother/hh#

Has mother been in program before? Y N

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Medicaid #: \_\_\_\_\_ SSN: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ / \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Language Written: \_\_\_\_\_

Estimated Due Date (EDC): \_\_\_\_\_ Planned Delivery Hospital: \_\_\_\_\_

Referred By: \_\_\_\_\_ Gravida \_\_\_\_\_ Para \_\_\_\_\_

Infant DOB: \_\_\_\_\_ Pregnancy Outcome: \_\_\_\_\_

Alternate Contact Information: \_\_\_\_\_

## Mother's Provider Information:

Doctor's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

## Mother'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: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

## Mother's Results of Serology Tests:

Type of Screen	Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
1 <sup>st</sup> Prenatal	HBsAg				
2 <sup>nd</sup> Prenatal	HBsAg				
Test at Delivery	HBsAg				
Carrier Status	HBsAg				
	Anti-HBs				
	Anti-HBc				

## Mother's Closure Information:

Date Case Closed: \_\_\_\_\_ Reason Closed: \_\_\_\_\_ Status: \_\_\_\_\_

## Other Information:

- A. Name of person completing summary: \_\_\_\_\_  
 Name of organization: \_\_\_\_\_  
 Address of organization: \_\_\_\_\_  
 Telephone number of organization: \_\_\_\_\_
- B. Copies of initial summary reports should be sent to the address below within: 1) 30 days following identification of the HBsAg-positive pregnant woman; 2) 30 days following the infant's birth; 3) 30 days following identification of each contact. Updated summary reports should also be mailed to the address below when: 1) after the mother completes any serology testing 2) after the infant completes vaccine series and after post-vaccine serology testing; 3) after contact's initial serology testing and when vaccine series is complete.
- Surveillance & Epidemiology  
 Immunization Division, Texas Department of Health  
 1100 West 49<sup>th</sup> Street  
 Austin, Texas 78756
- C. Vaccine serology for the infant: Collect specimen from infant at 12 months of age.
- D. If the mother, infant, or any contacts move from your jurisdiction before they have completed all prevention activities, forward the summary reports with new addresses and other patient information to the address above. If you have questions, please contact the Surveillance and Epidemiology, Immunization Division, Texas Department of Health at (800) 252-9152 or (512) 458-7284.