



Mother Case Management Report
Perinatal Hepatitis B Prevention Program
 Infectious Disease Intervention and Control Branch
 Texas Department of State Health Services
 PO Box 149347/ Mail code 1939
 Austin, Texas 78714-9347
 FAX: (512) 458-7787 PHONE: (512) 458-7447

Mother's Information:

Initial Report Date: ___/___/___ (mm/dd/yyyy) ID#: ___/___/___/___ (yr/county/mother/hh#)

Has mother been in program before? Yes No

Last Name:	First Name:	DOB:	/ /
Address:	City:	Zip:	County:
Home Phone: / -	Work Phone: / -	Medicaid #:	SS# - -
Race/Ethnicity:	Country of Birth:		
Language Spoken:	Language Written:		
Estimated Due Date (EDD): / /	Planned Delivery Hospital:		
Referred By:	Prenatal Care: Yes <input type="checkbox"/> No <input type="checkbox"/>	Gravida:	Para:
Infant DOB: / /	Pregnancy Outcome:		

Mother's Provider Information:

Doctor's Name:	Phone: / -	Fax: / -
Address:	City:	Zip:

Mother's Hepatitis B Serology and Vaccination History:

Prior hepatitis B serology test? No Yes (If yes indicate lab results)

Prior report HBsAg: Reactive Non Reactive Date: ___/___/___

Prior report anti-HBs: Reactive Non Reactive Date: ___/___/___

Prior report anti-HBc: Reactive Non Reactive Date: ___/___/___

Prior Hepatitis B vaccination history? No If Yes Dates: ____, ____, ____

Mother's Serology Tests Results:

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

Mother's Closure Information:

Date Case Closed: ___/___/___ Reason Closed: _____ Status: _____

Mother susceptible: Yes No

Hepatitis B vaccine series given: ____, ____, ____

Other Information:

- A. Name of case manager: _____
 Name of organization: _____
 Address of organization: _____
 Telephone number (include area code) of organization: _____
- B. Copies of initial case management reports should be sent by **FAX or MAIL within: 1) 15 days** following identification of the HBsAg-positive pregnant woman 2) **15 days** following the infant's birth; 3) **15 days** following identification of each contact. Updated case management reports should be FAXED or MAILED **AFTER:** 1) the mother completes any serology testing 2) the infant completes vaccine series and after post-vaccine serology testing; 3) contact's initial serology testing and when vaccine series and post-vaccination serology are complete .
- C. Vaccine serology for the infant: Collect specimen from infant 3 months after vaccine series is completed.
- D. If the mother, infant, or any contacts move from your jurisdiction before they have completed all prevention activities, forward the case management reports with new addresses and other patient information to the address above. If you have questions, please contact the Perinatal Hepatitis B Coordinator at the Department of State Health Services, Infectious Disease Intervention and Control Branch at (512) 458-7447.