Perinatal Hepatitis B Prevention Program
Infant Case Management Report

Mail Code 1946
P.O. Box 149347
Austin, Texas 78714 - 9347
Phone: (512) 776 - 6813
Fax: (512) 776 - 7544

Initial Report Date: ____________ (mm/dd/yyyy)

ID# _ _ _ _ / _ _ _ / _ _ _ / _ _ (year / county / mother / hh#)

Infant Information:

Last Name: ______________________ First Name: ______________________

Date of Birth: __________ (mm/dd/yyyy) Time of Birth: ________ ☐ A.M. ☐ P.M. Gender: ☐ Male ☐ Female

Birth Weight: ________ (in lbs.) **(< 4.4lbs = Low Birth Weight [LBW])** LBW: ☐ Yes ☐ No Safe Surrender: ☐ Yes ☐ No

Mother's First Name ______________ Mother's Last Name ______________ Mother's DOB: ________ (mm/dd/yyyy)

Address ______________ City ______________ State ____ Zip ______ County ______

Home Phone: ______________ Other Phone: ______________ Medicaid Number: ______________

Race / Ethnicity: ______________ Delivery Hospital: ______________

Emergency Contact Information: ______________________ Immtrac #: ________

Adoptive / Foster Parent / Guardian:

Name: ______________________ (Last, First) Phone: ______________

Address ______________ City ______________ State ____ Zip ______

Infant Provider Information:

Physician's Name: ______________________ Specialty / Type: ______________________

Address ______________ City ______________ State ____ Zip ______

Phone: ______________ Fax: ______________

Infant Vaccination Schedule Guide:

Series 1	**Low Birth Weight (< 4.4 lbs) (Needs 4 doses of Hep B vaccine)**	**Engerix / Recombivax (Monovalent)**	**Pediarix® (Combination)**
HBIG	Within 12 hours of birth	Within 12 hours of birth	Within 12 hours of birth
1st Hep B dose	Within 12 hours of birth - do not count birth dose as part of vaccine series	Within 12 hours of birth **(Monovalent)**	Within 12 hours of birth **(Monovalent)**
2nd Hep B dose	Age 1 month	Age 1 month	Age 2 months **(Pediarix®)**
3rd Hep B dose	Age 2 months	Age 6 months	Age 4 months **(Pediarix®)**
4th Hep B dose	Age 6 months	N/A	Age 6 months **(Pediarix®)**

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Last Name: ______________________ First Name: ______________________

HBIG and Hepatitis B Vaccine Record – Series 1:

Series 1	Date	Dose	Time	Formulation	Manufacturer	Lot Number	Provider (Doctor / Clinic)
HBIG							
1st Hep B dose							
2nd Hep B dose			N/A				
3rd Hep B dose			N/A				
4th Hep B dose			N/A				

Post Vaccine Serology Results – Series 1: (Must be performed 3 months after completing vaccine series)

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor / Clinic)
HBsAg		Reactive Non-Reactive		
Anti-HBs		Reactive Non-Reactive		
Anti-HBs Quantitative Results				

***If infant does not seroconvert, repeat one Hep B dose and do post vaccine serology testing 1 - 2 months after or repeat entire vaccine series and post vaccine serology testing, see page 4 and infant case management instructions for details.**

Comments:

*If Lost to Follow-up or Non-Compliant, please obtain vaccination and / or PVS record history from:

Immtrac: ☐ **Yes** ☐ **No** **Pediatric Health Care Provider:** ☐ **Yes** ☐ **No**

Prior to submitting the Case Management Report to the regional perinatal hepatitis B prevention nurse coordinator, please ensure that all appropriate areas of the form are completed. The Case Management Report MUST be submitted within 15 days after the initial report date. All updates should be sent immediately to the regional perinatal hepatitis B prevention nurse coordinator. If the infant moves from your jurisdiction before completing all prevention activities, please complete the Case Management Transfer form, include the new address and submit to the regional perinatal hepatitis B prevention nurse coordinator.

Infant Disposition: (refer to page 3 for closure and status codes)

Date Closed: ________ **Reason Closed:** ________ **Status:** ________

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Hepatitis B Vaccine Record – Series 2: *Complete Series 2 - IF INFANT* **DID NOT** *SEROCONVERT AFTER SERIES 1*

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

Post Vaccine Serology Results – Series 2: (Must be performed at least 1 month after completing vaccine[s])

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor / Clinic)
HBsAg		**Reactive** **Non-Reactive**		
Anti-HBs		**Reactive** **Non-Reactive**		
Anti-HBs Quantitative Results				

Infant Disposition:

Date Closed: ________ **Reason Closed:** ________ **Status:** ________

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Closure Codes	Explanation
1	Completed Case Management. (Completed vaccine series and post vaccine serology)
2	Death of Client.
3	Ineligible. (Use if mother is not HBsAg+)
4	Lost to Follow-up.
5	Moved Out of State.
6	Moved Out of Country.
7	Non-compliant / Refused.
8	Never Located.
9	Transferred within Jurisdiction.
10	Transferred to another jurisdiction within Texas.
11	Referred for Medical Follow-up. (Client is HBsAg positive)
Status Codes	**Explanation**
1	Immune. (Vaccinated)
2	Immune. (Resolved Infection)
3	Infected. (Carrier)
4	Vaccinated, not tested.
5	Susceptible. (PVST indicated not immune after 1st Hep B series.)
6	Non-responder. (PVST indicated not immune after 2nd Hep B series.)
7	Unknown.

Methods Used to Locate Client (Resources)		
Health Care Provider		
Pediatrician	Yes	No
FQHC	Yes	No
Primary	Yes	No
Lab	Yes	No
Phone Calls		
Date: ________	Time: ________	
Date: ________	Time: ________	
Date: ________	Time: ________	
Date: ________	Time: ________	
Date: ________	Time: ________	
Other		
411 Directory	Yes	No
First Class Mail	Yes	No
Certified Mail	Yes	No
Forwarding Address	Yes	No
Accurint	Yes	No
Home Visit		
Date: ________	Time: ________	
Date: ________	Time: ________	