TEXAS Health and Human Services | Texas Department of State Health Services

Perinatal Hepatitis B Prevention Program
Mother Case Management Report

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

ID# _ _ _ _ / _ _ _ / _ _ _ _ **/00**
(year / county / mother / hh#)

Initial Report Date: _____ (mm/dd/yyyy) Initial Contact Date: _____ (mm/dd/yyyy) Interview Date: _____ (mm/dd/yyyy)

Mother Information:

Previously enrolled? ☐ Yes ☐ No **Safe Surrender?** ☐ Yes ☐ No **Conducted Interview?** ☐ Yes ☐ No

Last Name _____ **First Name** _____ **Date of Birth:** _____ (mm/dd/yyyy)

Address _____ **City** _____ **State** _____ **Zip** _____ **County** _____

Home Phone: _____ **Other Phone:** _____ **Race / Ethnicity:** _____

Mother Country of Birth: _____ **Maternal Grandmother Country of Birth:** _____

Language(s) Spoken: _____ **Language Written:** _____

Estimated Due Date (EDD): _____ **Planned Delivery Hospital:** _____

Referred by: ☐ Hospital ☐ Lab ☐ Other State ☐ Surveillance ☐ Provider ☐ Self ☐ Epi ☐ Refugee Program

Prenatal Care? ☐ Yes ☐ No **Gravida:** _____ **Para:** _____

Infant DOB: _____ (mm/dd/yyyy) **Pregnancy Outcome:** ☐ Single ☐ Twin ☐ Triplet ☐ Stillborn ☐ Abortion ☐ Miscarriage

Mother Provider Information:

Physician's Name: _____ **Specialty / Type:** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone: _____ **Fax:** _____

Disaster Questionnaire:

In the event of a hurricane or natural disaster will you: ☐ Stay in town? ☐ Leave town?

If you leave town, address of where you would stay: ☐ Family ☐ Friends ☐ Other: _____

Address for this location _____ **City** _____ **State** _____ **Zip** _____

Phone for this location: _____

Mother Insurance Information:

Type of insurance? ☐ Private ☐ Medicaid **Medicaid #** _____ ☐ Uninsured

Sexual / Household Contacts _____

Any Sexual/Household Contacts? ☐ Yes ☐ No **If yes, complete the information below:**

Number of sexual / household contacts older than 24 months of age identified. _____

Number of sexual / household contacts older than 24 months of age referred for health care follow-up. _____

Number of household contacts ≤ 24 months of age enrolled in program. _____
(A contact CMR must be completed for all contacts ≤ 24 months of age.)

Last Name: _____ First Name: _____

Prior Mother Hepatitis B History:

Prior Pregnancy? ☐ Yes ☐ No If Yes, number of prior infants infected _____
Number of prior infants immune _____

Prior hepatitis B serology test? ☐ Yes ☐ No 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? ☐ Yes ☐ No If yes, dates: _____, _____, _____

Mother Being Monitored for Hep B? ☐ Yes ☐ No If Yes, Provider Name: _____
Mother Receiving Anti-Viral Treatment? ☐ Yes ☐ No If Yes, date Started: _____

Name of Treatment Medication: _____ Dates _____
Name of Treatment Medication: _____ Dates _____

Mother Serology Tests Results:

Type of Screen	Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor / Clinic)
1st Prenatal	HBsAg	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Anti-HBs	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Anti-HBc	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Core IgM-IgG	_____	☐ Reactive ☐ Non-Reactive	_____	_____
Test at Delivery	HBsAg	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Anti-HBs	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Anti-HBc	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Core IgM-IgG	_____	☐ Reactive ☐ Non-Reactive	_____	_____
Carrier Status	HBsAg	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Anti-HBs	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	Anti-HBc	_____	☐ Reactive ☐ Non-Reactive	_____	_____
Additional Serology	HBeAg	_____	☐ Reactive ☐ Non-Reactive	_____	_____
	DNA Viral Load	_____		_____	_____

Any reportable infections/conditions? ☐ Yes ☐ No ☐ Hepatitis C ☐ HIV ☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ TB

Referred for Medical Follow up? ☐ Yes ☐ No Physician's Name: _____ Specialty / Type: _____

Comments:

Disposition: (refer to chart on next page for closure and status codes)
Date Closed: _____ Reason Closed: _____ Status: _____

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(year / county / mother / hh#)

Last Name: _____ **First Name:** _____

Other Information:

Name of case manager: _____

Name of organization: _____

Address of organization: _____

Telephone number of organization: _____

- **The initial interview of index case should be performed within 15 days following the identification of the HBsAg-positive pregnant woman.**
- **The case management report should be sent by FAX or MAIL within 7 days following identification of the HBsAg-positive pregnant woman to the regional perinatal hepatitis B prevention nurse coordinator. Updated case management reports should be FAXED or MAILED IMMEDIATELY AFTER the mother completes any serology testing to the regional perinatal hepatitis B prevention nurse coordinator.**
- **If the mother moves from your jurisdiction before completing all prevention activities, complete the Case Management Transfer form, include the new address and submit to the regional perinatal hepatitis B prevention nurse coordinator within 15 days of notification.**

Closure Codes	Explanation
1	Completed Service. (Screened or had previous documentation of testing)
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 or resolved infection)
2	Infected. (acute or carrier)
3	Discrepant Result.
4	Susceptible.
5	Unknown.

Methods Used to Locate Client		
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: _____	