



Texas Department of State Health Services

Perinatal Hepatitis B Prevention Program Case Management Transfer Form

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[ ] In-State [ ] Out-of-State [ ] Open in New Jurisdiction

Transferring County: \_\_\_\_\_ Receiving County / State: \_\_\_\_\_

Index Case ID#: \_\_\_\_/\_\_\_\_/\_\_\_\_/00
(year / county / mother / hh#)

Index Case:

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

New Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

New Phone Number: ( ) \_\_\_\_\_

New Index Case ID#: \_\_\_\_/\_\_\_\_/\_\_\_\_/00
(year / county / mother / hh#)

Table with 2 columns: Field Name, Value. Fields include Attention, Fax Number, From, Date Sent, Total # of Pages.

Additional Comments: \_\_\_\_\_

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