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

Last Name: _____ First Name: _____

Contact Hepatitis B Serology and Vaccination History:

Prior hepatitis B serology test?	☐ Not Interviewed	☐ No	☐ Yes (If yes, indicate lab results) _____
Prior report HBsAg:	☐ Reactive	☐ Non-Reactive	Date:_____
Prior report anti-HBs:	☐ Reactive	☐ Non-Reactive	Date:_____
Prior anti-HBs Quantitative Results:	☐ No	☐ Yes	If Yes, Results
Prior hepatitis B vaccination history:	☐ No	☐ Yes	If yes, dates: _____, _____, _____
HBIG at Birth:	☐ No	☐ Yes	If yes, dates: _____, _____, _____

Serology Test Results Performed After Initial Report Date:

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

Hepatitis B Vaccine – Series 1 (Given After Initial Report Date):

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

Post Vaccine Serology Results – Series 1

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 contact does not seroconvert begin second series see page 3.**

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.

Contact Disposition: (refer to chart on page 4 for closure and status codes)

Date Closed: _____ **Reason Closed:** _____ **Status:** _____

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

Perinatal Hepatitis B Prevention Program
Contact < 24 Months Case Management Report

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

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

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

Hepatitis B Vaccine – Series 2: *Complete Series 2:* **IF CONTACT DOES NOT SEROCONVERT AFTER SERIES 1**

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

Post Vaccine Serology Results – Series 2:

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

Contact Disposition: (refer to chart on page 4 for closure and status codes)

Date Closed: _____ **Reason Closed:** _____ **Status:** _____

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

Last Name: _____ First Name: _____

Closure Codes	Explanation
1	Completed Case Management (Completed vaccine series and post vaccine serology)
2	Completed Service (Screened or had previous documentation of testing)
3	Death of Client
4	Ineligible (Use if mother is not HBsAg+)
5	Lost to Follow-up
6	Moved Out of State
7	Moved Out of Country
8	Non-compliant / Refused
9	Never Located
10	Transferred within Jurisdiction
11	Transferred to San Antonio / Houston
12	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
6	Non-responder
7	Unknown

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: _____	