Philadelphia Department of Public Health
Division of Disease Control, Immunization Program

Perinatal Hepatitis B Prevention Program Report Form

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REPORTED BY_____ **DATE**_____ **CASE NUMBER**_____ **FAMILY NUMBER**_____

ASSIGNED TO_____ **DATE**_____ **DATE INITIATED**_____

Name of Mother/Pregnant Woman_____ **DOB** _____ **Age** _____

1ST Address_____ **Telephone** _____

2ST Address_____ **Telephone** _____

Contact Person_____ **Relationship**_____ **Telephone**_____

Mother's Country of Birth_____ **Language**_____

Race. Ethnicity (circle): B W HISP A/PI CARRIBBEAN NAT.AM/ALASK.NATIVE OTHER:

EDD:_____ **G**_____ **P**_____ **Prenatal care? Yes**_____ **No**_____ **Provider**_____

Address_____ **Clinic Contact**_____ **Telephone**_____

LABORATORY TESTS OF MOTHER

TEST	DATE OF TEST	TRIMESTER	RESULTS	LABORATORY	DATE REPORTED
HBsAg #1					
HBsAg #2					
HBeAg					
HBV-DNA					
Anti-HBc					
Anti-HBe					
Anti-HBs					

PREGNANCY OUTCOME **DATE:** _____ **MISCARRIED/TERMINATED:** _____ **NEONATAL DEATH:** _____

LIVE BIRTH: _____ **NO. INFANTS:** _____ **SEX:** _____ **HOSPITAL:** _____

INFANT'S NAME:_____ **PEDIATRICIAN:**_____ **TEL NO:** _____

VACCINE	DATE	BRAND/FORMULATION	DOSE	LOT #	SITE	ADMINISTRATOR	REPORTER/DATE
HBIG							
HBV #1							
HBV #2							
HBV #3							
POST-VACCINE	**HBsAg**	**RESULTS**	**DATE**	**ANTI -HBs**	**DATE**	**RESULTS**	**IMMUNE/CARRIER/ SUSCEPTIBLE**
SCREENS							

Date Case Closed _____ Reason_____