

EPID 395: Kentucky Perinatal Hepatitis B Prevention Case Management Work Sheet

PART 1: MATERNAL		
NAME	DOB	EDC
ADDRESS	ETHNICITY	BIRTHING HOSPITAL
	COUNTY	PHONE NUMBER
DATE OF HBsAg TESTING	STATE	
HBsAg TEST RESULT	PHONE(H)	MOTHER'S INSURANCE TYPE
MD	PHONE (C)	
MD PHONE NUMBER	PHONE (W)	LANGUAGE SPOKEN

PART 2: HOUSEHOLD/SEXUAL CONTACTS	PART 3: INFANT
<p># OF HOUSEHOLD CONTACTS:</p> <p># RECEIVING PREVACCINATION SEROLOGICAL TESTING</p> <p># HBsAg-POSITIVE # IMMUNE TO HBV</p> <p>#SUSCEPTIBLE #VACCINATED THIS PREGANCY</p>	<p>NAME DOB WEIGHT</p> <p>ADDRESS:</p> <p>COUNTY</p> <p>STATE</p> <p>MD FOR VACCINATIONS/ PHONE NUMBER</p>

Part 4 INFANT'S VACCINATIONS/ POST VACCINATION SEROLOGY RESULTS							
<p>DATE OF HBIG</p> <p>DATE OF HEPATITIS VACCINE/BRAND</p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%;">HBV 1</td> <td style="width: 50%;">HBV4 (if needed)</td> </tr> <tr> <td>HBV2</td> <td>HBV5 (if needed)</td> </tr> <tr> <td>HBV3</td> <td>HBV6 (if needed)</td> </tr> </table>	HBV 1	HBV4 (if needed)	HBV2	HBV5 (if needed)	HBV3	HBV6 (if needed)	<p>HEPATITIS B SURFACE ANTIGEN (HBsAg)</p> <p>ANTIBODY TO HEPATITIS B SURFACE ANTIGEN – QUANTITATIVE (ANTI-HBs)</p> <p>REPEATED RESULTS, IF NEEDED</p> <p>HBsAg ANTI-HBs</p>
HBV 1	HBV4 (if needed)						
HBV2	HBV5 (if needed)						
HBV3	HBV6 (if needed)						

PART 4 CASE NOTES

Please send all updates to the Kentucky Perinatal Hepatitis B Prevention Program Coordinator at 275 E. Main Street HS2E-B, Frankfort, KY 40601 or Fax 502-696-3803 or 855-568-8601