Mail to: California Department of Public Health
Immunization Branch
850 Marina Bay Parkway
Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
OR Fax to: (510) 620-3949

PERINATAL HEPATITIS B CASE REPORT

This form is to be used for infants aged 1-24 months found to be infected with hepatitis B virus

CASE IDENTIFICATION AND DEMOGRAPHICS

PATIENT'S NAME—*Last* *First* *Middle initial* | **PHONE** ( )

STREET ADDRESS | **CITY** | **STATE** | **ZIP** | **COUNTY**

DOB *(month/day/year)* / / | **AGE** *(enter age and check one)* ____ ☐Days ☐Weeks ☐Months ☐Years | **SEX** ☐M ☐F | **COUNTRY OF BIRTH** ☐USA ☐OTHER: _____ | **DATE OF REPORT** / /

ETHNICITY (*check one*)
☐Hispanic/Latino
☐Non-Hispanic/ Non-Latino
☐Unknown

RACE *(check all that apply)*
☐Black/African-American
☐Native American/Alaskan Native
☐White
☐Unknown
☐Other:_____
☐Asian: *Please specify:*
☐Asian Indian ☐Hmong ☐Thai
☐Cambodian ☐Japanese ☐Vietnamese
☐Chinese ☐Korean ☐Other Asian: _____
☐Filipino ☐Laotian
☐Pacific Islander: *Please specify:*
☐Native Hawaiian
☐Guamanian
☐Samoan
☐Other Pacific Islander: _____

REASONS FOR TESTING *(check all that apply)*
☐ Symptoms of acute hepatitis ☐ Evaluation of liver enzymes
☐ Postvaccination serologic testing ☐Other:_____

WAS INFANT ENROLLED IN CA PHPP? *(If 'Yes' enter ID below)*
☐Yes ☐No: Why not enrolled? :_____
☐Unknown

PHYSICIAN NAME *(name, facility)* | **PHYSICIAN PHONE** ( ) | **CMR ID** | **PHPP ID**

CLINICAL AND DIAGNOSTIC DATA

SYMPTOMATIC? ☐Yes ☐No ☐Unknown

SYMPTOMS *(check al)*
☐Jaundice ☐Diarrhea
☐Dark urine ☐Anorexia
☐Other _____

ONSET OF SYMPTOMS / /

DIAGNOSIS DATE (test date) / /

HOSPITALIZED? ☐Yes ☐No ☐Unk

ADMIT DATE / /

DIED OF HEPATITIS? ☐Yes ☐No ☐Unk

DATE OF DEATH / /

INFANT'S HEPATITIS B DIAGNOSTIC TESTS *(required)*

	Positive	*Negative*	*Unk*	*Month/Day/Year*
HBsAg	☐	☐	☐	__/__/____
anti-HBs	☐	☐	☐	__/__/____
anti-HBc total	☐	☐	☐	__/__/____
anti-HBc IgM	☐	☐	☐	__/__/____
HBeAg	☐	☐	☐	__/__/____
Anti-HBe	☐	☐	☐	__/__/____
Other ____	☐	☐	☐	__/__/____

INFANT'S LIVER ENZYME LEVELS AT DIAGNOSIS *Month/Day/Year*
ALT [SGPT] Result _____ Upper limit normal _____ __/__/____
AST [SGOT] Result _____ Upper limit normal _____ __/__/____
Bilirubin _____ __/__/____

INFANT'S HEPATITIS B VACCINE HISTORY

Dose received	*Age in hours if <24*	*Month/Day/Year*	*Date unk*
☐HBIG	_____	__/__/____	☐
☐Dose #1	_____	__/__/____	☐
☐Dose #2		__/__/____	☐
☐Dose #3		__/__/____	☐
☐Dose #4		__/__/____	☐

☐None ☐Unknown

MOTHER'S INFORMATION

MOTHER'S ETHNICTY
☐Hispanic/Latino
☐Non-Hispanic/ Non-Latino
☐Unknown

MOTHER'S RACE *(please specify)*
☐Asian:_____
☐Black/African-American
☐Native American/Alaskan Native
☐Pacific Islander: _____
☐White
☐Unknown
☐Other:_____

MOTHER'S COUNTRY OF BIRTH
☐USA ☐OTHER: _____

WAS MOTHER CONFIRMED HBsAg POSITIVE PRIOR TO OR AT DELIVERY? ☐Yes ☐No ☐Unk

IF 'No', WAS MOTHER CONFIRMED HBsAg POSITIVE AFTER DELIVERY? ☐Yes ☐No ☐Unk

MOTHER'S HEPATITIS B DIAGNOSTIC TESTS

	Positive	*Negative*	*Unk*	*MM/DD/YYYY*
HBsAg	☐	☐	☐	__/__/____
HBeAg	☐	☐	☐	__/__/____
anti-HBe	☐	☐	☐	__/__/____
Other ____	☐	☐	☐	__/__/____
HBV DNA	_____			__/__/____

DID MOTHER RECEIVE ANTIVIRAL TREATMENT (e.g. lamivudine) **OR HBIG DURING PREGNANCY?**
☐Yes ☐No ☐Unk

NOTES

PERINATAL HEPATITIS B INFORMATION*

Case definition: HBsAg positivity in any infant aged >1-24 months who was born in the United States or in U.S. territories to an HBsAg-positive mother

Postexposure prophylaxis: All infants born to HBsAg-positive women should receive single-antigen hepatitis B vaccine and HBIG ≤12 hours of birth and complete the vaccine series according to the recommended schedule with the final dose administered after age 24 weeks.

Postvaccination serologic testing: Testing for anti-HBs and HBsAg should be performed after completion of the vaccine series (or 3rd dose), at age 9—18 months.

COMPLETED BY | **LHD** | **DATE COMPLETED** / / | **PHONE** ( ) | **REPORT TO CDPH** / /

**See the Hepatitis B Quicksheet for additional information*

OPTIONAL HOUSEHOLD MANAGEMENT/FOLLOW-UP

Name	Age	Gender	Relationship to case	Hepatitis B status: Immune (anti-HBs positive)	Hepatitis B status: Infected (HBsAg positive)	Hepatitis B status: Unknown	CA PHPP ID (if applicable)
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	

NOTES