Louisiana Department of Health and Hospitals
Office of Public Health
PERINATAL HEPATITIS B SURVEILLANCE FORM

DATE OF REPORT: ____/____/____

SECTION I: PRENATAL CARE
PART A: MOTHER INFORMATION **CASE# ______________**

1. Last Name ___________________________________ 2. First Name: ____

3. Address ______________________________________ 4. Address #2 ____

4. City ________________________________ 5. Zip _________ 6. Parish ________________________________

7. Phone _____________________________ Alternate phone: ____

8. Age ________ 9. Date of Birth _____/____/____ 10: Primary Language ______________________

11. Race (check): ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Other _____________________

12. Ethnicity: ☐ Hispanic ☐ Non-Hispanic

PART B: MEDICAL INFORMATION (Mother)

1. Prenatal Care Received? ☐ Yes ☐ No
1. Health Insurance Status: ☐ Medicaid ☐ Private Insurance ☐ Other ____________________________
2. Name of Prenatal Care Provider: ___________________________________
3. Clinic address: ______________________________________ Clinic Phone: _________________________
4. Clinic City: ________________________ Clinic Fax/email address: ____

5. Collection Date of Hepatitis B Labwork: Date _____/_____/_____ Date 2 _____/_____/_____

PLEASE ATTACH A COPY OF THE PATIENT'S HEPATITIS B LAB RESULTS WITH THIS REPORT

6. Expected Date of Delivery: _____/_____/_____
7. Expected Hospital of Delivery: ____

SECTION II: DELIVERY HOSPITAL CARE
Part A: Mother Information

1. Pregnancy Outcome: ☐ Live birth ☐ Stillborn ☐ Miscarriage ☐ Pregnancy Terminated
2. Hospital of delivery ____

Part B: Infant Information

1. Last Name _______________________________________ 2. First Name: ___________________________________
2. Date of Birth ______/_____/_____ 4. Birth Time _______/_____ am/pm (*circle*) 5. Birth Weight _________________
6. Health Insurance Status at Birth: ☐ Medicaid ☐ Private ☐ Other __________________________
7. Sex: ☐ Female ☐ Male
8. Date HBIG Administered: _____/_____/____ 9. Time HBIG Given: ______/______ am/pm (*circle*)
10. 1st Dose Hep B vaccine date: ___/___/___ Time 1st HBV dose: _______/_____ am/pm (*circle*)
11. Name of Pediatrician: _____________________________ Clinic Phone: ______________________________
12. Pediatrician Address: ______________________________ Clinic fax/email address: _______________________

Please fax or mail form to:

Louisiana Department of Health and Hospitals
Office of Public Health – Immunization Program
Attn: Perinatal Hepatitis B Program
1450 Poydras St.; Ste 1938
PH: (504) 568-2600 FAX: (504) 568- 2659

For Office Use Only

Section III INFANT'S VACCINE RECORD **LINKS SIIS: ________________________**

Part A. Hepatitis B Vaccine

1. HBV Series One:

HBV Dose 1: ___/___/___ 2. HBV Dose 2: ___/___/___ 3. HBV Dose 3: ___/___/___ HBV Dose 4: ____/___/____

2. HBV Series Two (explain): ____

HBV Dose 1: ___/___/___ 2. HBV Dose 2: ___/___/___ 3. HBV Dose 3: ___/___/___ HBV Dose 4: ____/___/____

Part B: Infant's Post-Vaccination Testing - PVST (9 – 12 months of age)

Date Collected: ____/____/_____

HBsAg ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Hepatitis B Surface Antibody

or Anti HBs ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Total Anti-HBc, IgG ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Total Anti-HBc, IgM ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Repeat PVST Testing (if needed) Date: ___/____/_____

HBsAg ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Hepatitis B Surface Antibody or

Anti- HBs ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Total Anti-HBc, IgG ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

Total Anti-HBc, IgM ☐ Positive/Reactive ☐ Negative/Non-Reactive ☐ Not done

SECTION IV CASE DISPOSITION

Date: ___/___/____

- ☐ Case Completed
- ☐ Lost to Follow up/ unable to locate
- ☐ Non-compliance by parent/guardian
- ☐ Transfer out of state
- ☐ Death of client
- ☐ False (+) Mother
- ☐ Susceptible – not immune after 1st HBV series
- ☐ Non-responder after second HBV series
- ☐ Infant (+) HBsAg - NNDSS Case #: ________________________

SECTION V

COMMENTS: ____

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