



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 SECTION FOR DISEASE PREVENTION
 PERINATAL HEPATITIS B PREVENTION AND
 CASE MANAGEMENT PROGRAM
**CASE CONTACT REPORT FOR CONTACTS OF
 PREGNANT HBSAG – POSITIVE WOMEN**

DATE OF REPORT (TO BE FILLED OUT BY SUBMITTER)	ORIGINAL PREGNANT FEMALE NAME
	WEBSURV CID:

CONTACT #1 AND HOUSEHOLD CASE DEMOGRAPHIC

NUMBER OF ADULTS IN HOUSEHOLD:		NUMBER OF CHILDREN IN HOUSEHOLD		DATE OF BIRTH	RELATIONSHIP TO ORIGINAL CASE
NAME					
ADDRESS				CITY	
STATE	ZIP CODE	COUNTY		WORK TELEPHONE NUMBER	HOME TELEPHONE NUMBER
COUNTRY OF BIRTH	RACE (CHECK ONE) <input type="checkbox"/> NATIVE AMER/ALASKAN NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> OTHER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> UNKOWN		ETHNICITY (CHECK ONE) <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON HISPANIC <input type="checkbox"/> UNKOWN		LANGUAGE (WRITE IN) GENDER <input type="checkbox"/> M <input type="checkbox"/> F

TEST RESULTS

DATE	HBsAg	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE
DATE	Anti-HBc IgM	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE
DATE	Anti-HBc (total)	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE
DATE	Anti-HBs	<input type="checkbox"/> POSITIVE/REACTIVE ≥ 10 IU/mL	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE

PROPHYLAXIS PROVIDER

DATE	HBIG	
DATE	HB Dose #1 Hep B Vac	
DATE	HB Dose #2 Hep B Vac	
DATE	HB Dose #3 Hep B Vac	
DATE	HB Dose #4 Hep B Vac (if needed, see Pink Book)	

CASE RESOLUTION DATE	REASON <input type="checkbox"/> IMMUNITY DUE TO VACCINATION <input type="checkbox"/> IMMUNITY DUE TO NATURAL INFECTION <input type="checkbox"/> CHRONIC INFECTION	DATE RECEIVED BY DHSS	DATE ENTERED INTO WEBSURV	WEBSURV CONDITION ID
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CONTACT #2 AND HOUSEHOLD CASE DEMOGRAPHIC

NUMBER OF ADULTS IN HOUSEHOLD		NUMBER OF CHILDREN IN HOUSEHOLD		DATE OF BIRTH	RELATIONSHIP TO ORIGINAL CASE
NAME					
ADDRESS				CITY	
STATE	ZIP CODE	COUNTY		WORK TELEPHONE NUMBER	HOME TELEPHONE NUMBER
COUNTRY OF BIRTH	RACE (CHECK ONE) <input type="checkbox"/> NATIVE AMER/ALASKAN NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> OTHER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> UNKOWN		ETHNICITY (CHECK ONE) <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON HISPANIC <input type="checkbox"/> UNKOWN		LANGUAGE (WRITE IN) GENDER <input type="checkbox"/> M <input type="checkbox"/> F

TEST RESULTS

DATE	HBsAg	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE
DATE	Anti-HBc IgM	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE
DATE	Anti-HBc (total)	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE
DATE	Anti-HBs	<input type="checkbox"/> POSITIVE/REACTIVE ≥ 10 IU/mL	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE

PROPHYLAXIS		PROVIDER			
DATE	HBIG				
DATE	HB Dose #1 Hep B Vac				
DATE	HB Dose #2 Hep B Vac				
DATE	HB Dose #3 Hep B Vac				
DATE	HB Dose #4 Hep B Vac (if needed, see Pink Book)				
CASE RESOLUTION DATE	REASON <input type="checkbox"/> IMMUNITY DUE TO VACCINATION <input type="checkbox"/> IMMUNITY DUE TO NATURAL INFECTION <input type="checkbox"/> CHRONIC INFECTION	DATE RECEIVED BY DHSS	DATE ENTERED INTO WEBSURV	WEBSURV CONDITION ID	
CONTACT #3 AND HOUSEHOLD CASE DEMOGRAPHIC					
NUMBER OF ADULTS IN HOUSEHOLD		NUMBER OF CHILDREN IN HOUSEHOLD		DATE OF BIRTH	RELATIONSHIP TO ORIGINAL CASE
NAME					
ADDRESS					
STATE	ZIP CODE	COUNTY	CITY	WORK TELEPHONE NUMBER	HOME TELEPHONE NUMBER
COUNTRY OF BIRTH	RACE (CHECK ONE) <input type="checkbox"/> NATIVE AMER/ALASKAN NATIVE <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMERICAN	<input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> UNKOWN	ETHNICITY (CHECK ONE) <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON HISPANIC <input type="checkbox"/> UNKOWN	LANGUAGE (WRITE IN)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
TEST RESULTS					
DATE	HBsAg	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE	
DATE	Anti-HBc IgM	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE	
DATE	Anti-HBc (total)	<input type="checkbox"/> POSITIVE/REACTIVE	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE	
DATE	Anti-HBs	<input type="checkbox"/> POSITIVE/REACTIVE ≥ 10 IU/mL	<input type="checkbox"/> NEGATIVE/NON-REACTIVE	<input type="checkbox"/> NOT DONE	
PROPHYLAXIS		PROVIDER			
DATE	HBIG				
DATE	HB Dose #1 Hep B Vac				
DATE	HB Dose #2 Hep B Vac				
DATE	HB Dose #3 Hep B Vac				
DATE	HB Dose #4 Hep B Vac (if needed, see Pink Book)				
CASE RESOLUTION DATE	REASON <input type="checkbox"/> IMMUNITY DUE TO VACCINATION <input type="checkbox"/> IMMUNITY DUE TO NATURAL INFECTION <input type="checkbox"/> CHRONIC INFECTION	DATE RECEIVED BY DHSS	DATE ENTERED INTO WEBSURV	WEBSURV CONDITION ID	
NOTES:					
Please submit to Disease Investigation Unit of the Missouri Department of Health and Senior Services; P.O. Box 570; Jefferson City, MO 65102-0570. Telephone: 573-751-6439 Fax: 573-751-6417					