New Jersey Department of Health
Vaccine Preventable Disease Program
P. O. Box 369, Trenton, NJ 08625-0369

CONFIDENTIAL PERINATAL HEPATITIS-B CASE AND CONTACT REPORT

Instructions: Please complete all sections of this form. Print or type all information. Insert "Month/Day/Year" in all fields requiring a date. Questions can be addressed to the New Jersey Department of Health, Vaccine Preventable Disease Program at 609-826-4860.

Review the instructions for completion of the form and distribution of copies.

Name of Agency Making Report | Report Date *(MM/DD/YY)* __ / __ / __

Name of Contact Person | Telephone Number ( )

SECTION I: DATA ON PRENATAL WOMAN

Name - Last | First | MI | County | CDRSS Case No.

Street Address | Apt. No. | Home Telephone Number ( )

City | State | Zip Code | Emergency Telephone Number ( )

Date of Birth *(MM/DD/YY)* __ / __ / __ | Age in Years

Ethnicity/Race (Check Only One)
1☐American Indian/Alaskan Native 2☐Asian/Pacific Islander 3☐Black 4☐Hispanic 5☐White 6☐Other (Specify) ____________ 7☐Unknown

Receiving/Received Prenatal Care ☐ Yes ☐ No | Date of HBsAg(+) Test *(MM/DD/YY)* __ / __ / __ | EDC *(MM/DD/YY)* __ / __ / __

Name of Hospital/Delivery Site | Telephone Number ( )

Address

Name of Prenatal Provider | Telephone Number ( )

Name of Pediatric Provider | Telephone Number ( )

SECTION II: DATA ON CONTACT(S)

Name of Local Health Department or Other Case Management Agency | Report Date *(MM/DD/YY)* __ / __ / __

Name of Contact Person | Telephone Number ( )

Name of Contact (Last Name, First Name) Telephone Number	Relation-ship	Date of Birth	Sex	Serologic Screening				Immunization Dates				
				Done? Y/N	Date Tested	Test Type	Result (+/-)	HB #1	HB #2	HB #3	HBIG	Outcome Code *

NOTE: If more contacts are identified, attach an additional sheet to this report.

SECTION III: DATA ON NEWBORN

Outcome of Pregnancy
a. Number of Live Infants _______ b. Pregnancy Terminated: ☐ Yes ☐ No | Infant NJ Immunization Registry Number

Infant Name - Last | First | MI | Date of Birth *(MM/DD/YY)* __ / __ / __

Sex ☐ Male ☐ Female

Ethnicity/Race *(Check Only One)*
1☐American Indian/Alaskan Native 2☐Asian/Pacific Islander 3☐Black 4☐Hispanic 5☐White 6☐Other (Specify) _________ 7☐Unknown

Date Vaccinated *(MM/DD/YY)*

HBIG __ / __ / __
HB #1 __ / __ / __
HB #2 __ / __ / __
HB #3 __ / __ / __
HB #4 __ / __ / __
HB #5 __ / __ / __
HB #6 __ / __ / __

Outcome Code *

Serology at 9 - 18 Months of Age

Serology Performed? ☐Yes ☐No

Lab Test	Date Performed *(MM/DD/YY)*	Result
HBsAg	__ / __ / __	☐Pos. ☐Neg. ☐Unk.
Anti-HBs	__ / __ / __	☐Pos. ☐Neg. ☐Unk.

(Anti-HBs ≥ 10 MIU/mL is positive result = immunity)

Serology Performed? ☐Yes ☐No

Lab Test	Date Performed *(MM/DD/YY)*	Result
HBsAg	__ / __ / __	☐Pos. ☐Neg. ☐Unk.
Anti-HBs	__ / __ / __	☐Pos. ☐Neg. ☐Unk.

*See Outcome Codes listed on Instruction page.