Perinatal Hepatitis B Prevention Program

Case Management Report

ORPHEUS ID

☐ confirmed
☐ presumptive
☐ not suspect
☐ no case

☐ Mother
☐ Infant
☐ Other contact

MOTHER'S INFORMATION

Mother's Name _____
LAST, first, initials (a.k.a.)

County_____

Special housing
- ☐ Nursing home/Asst Living
- ☐ Homeless
- ☐ Prison/jail
- ☐ Foster home
- ☐ Hospital
- ☐ Other institution
- ☐ Drug treatment shelter
- ☐ Women's shelter
- ☐ YES house
- ☐ Homeless shelter
- ☐ Job Corps
- ☐ Treatment Center
- ☐ Chemewa Indian School

Address _____
Street City Zip

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail _____

ALTERNATE CONTACT

Name _____ Phone(s)_____
LAST, first, initials home (H), work (W), cell (C), message (M)

DEMOGRAPHICS

DOB ___/___/___ if DOB unknown, AGE _____ Sex ☐ Female ☐ Male Preg ☐ Y ☐ N ☐ unk
m d y

Language _____ Country of birth _____ ☐ refugee

Worksites/school/day care center _____ Occupation/grade_____

RACE (*check all that apply*)

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Pacific Islander
- ☐ American Indian/ Alaska Native
- ☐ Unknown
- ☐ Refused
- ☐ Other_____

HISPANIC
- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Declined

SUBRACE
- ☐ American Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

_____

- ☐ Guamanian or Chamorro
- ☐ Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ Other Pacific Islander

_____

- ☐ Cuban
- ☐ Chicano/a
- ☐ Latino/a
- ☐ Mexican
- ☐ Mexican American
- ☐ Puerto Rican
- ☐ Spanish
- ☐ Other Hispanic

_____

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Oh

Reporter Name/Phone
_____
_____
_____

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Oth
HCP 2nd Prov

Reporter Name/Phone
_____
_____
_____

☐ Ok to contact patient (only list once)
Local epi_name_____
Date report received by LHD ___/___/___LHD completion date ___/___/___

MOTHER'S HISTORY

HBsAg test result (during this pregnancy)
☐ Pos ☐ Neg ☐ Not done
Collection date ___/___/___

Lab name _____

Known acute hep b ☐ Y ☐ N
Diagnosis date ___/___/___

Known chronic carrier ☐ Y ☐ N
Diagnosis date ___/___/___

	Pos	Neg	Not done	unk	Collection date
HBsAg	☐	☐	☐	☐	__/__/__
IgM anti-HBc	☐	☐	☐	☐	__/__/__
total anti-HBc	☐	☐	☐	☐	__/__/__
Anti-HBs	☐	☐	☐	☐	__/__/__
HBV DNA (PCR)	☐	☐	☐	☐	__/__/__
HBeAg	☐	☐	☐	☐	__/__/__

MOTHER'S NAME _____

PREGNANCY INFORMATION

Trimester screened for hepatitis B ☐ 1st ☐ 2nd ☐ 3rd ☐ at delivery ☐ transferred from out of state

Pregnancy #_____ Estimated delivery date ____/____/____ Delivery hospital _____
Mother's type of insurance ☐ Private ☐ Public ☐ Self-pay/no insurance ☐ unk
Infant's type of insurance ☐ Private ☐ Public ☐ Self-pay/no insurance ☐ unk

INFANT'S INFORMATION

Infant's Name _____ County_____
LAST, first, initials (a.k.a.)

DOB ___/___/___ Birth weight_____ Sex ☐ Female ☐ Male
m d y

Pediatrician or Clinic Name
_____

Address _____

Phone _____ Fax _____

Infant's ethnicity (*check all that apply*)

HISPANIC
☐ Yes ☐ No
☐ unknown ☐ refused

☐ White ☐ Black
☐ Asian ☐ Pacific Islander
☐ American Indian/ Alaska Native
☐ unk ☐ refused
☐ other_____

Was hepatitis B immune globulin (HBIG) administered?
☐ yes ☐ no ☐ unk Date:___/___/___

Did the infant recieve hepatitis B vaccine? ☐ yes ☐ no ☐ unk

	Date	Vaccine Type	
Dose 1	___/___/___		S - Single antigen
Dose 2	___/___/___		C-Combination vaccine
Dose 3	___/___/___		
Dose 4	___/___/___		U - unknown
Dose 5	___/___/___		
Dose 6	___/___/___		

Date serology completed: ___/___/___

Lab name: _____

HBsAg result ☐ Pos ☐ Neg ☐ Not done ☐ unk

If positive, infant's Orpheus case ID _____

Anti-HBs results ☐ Pos ☐ Neg ☐ Not done ☐ unk

Anti-HBs quant _____

Other lab results received

	Pos	Neg	Not done	unk
total anti-HBc	☐	☐	☐	☐
HBV DNA (PCR)	☐	☐	☐	☐
HBeAg	☐	☐	☐	☐

Date closed to case management: ____/____/___

Reason case management complete

☐ Services completed ☐ Lost to follow up ☐ Refused services
☐ Moved out of country ☐ Moved out of state ☐ Transferred out of state
☐ Infant died ☐ Household chronic carrier

MOTHER'S NAME _____

CONTACT'S INFORMATION

Contact's Name _____ Phones _____

LAST, first, initials

Specify: Home (H), Work (W), Cell (C), Message (M)

Address _____ County _____

Street City Zip

Contact's DOB ___/___/___

m d y

Sex ☐ Female ☐ Male

Relation to case

☐ Household ☐ Sexual ☐ Friend

☐ Needle sharing ☐ Other_____

Contact's ethnicity (*check all that apply*)

HISPANIC

☐ Yes ☐ No

☐ unknown ☐ refused

☐ White ☐ Black

☐ Asian ☐ Pacific Islander

☐ American Indian/ Alaska Native

☐ unk ☐ refused

☐ other_____

Prevaccination serology information

Collection date ___/___/___

Lab Name _____

	Pos	Neg	Not done	unk
Total anti-HBc	☐	☐	☐	☐
HBsAg	☐	☐	☐	☐
Anti-HBs	☐	☐	☐	☐
Other labs				
IgM anti-HBc	☐	☐	☐	☐
HBV DNA (PCR)	☐	☐	☐	☐
HBeAg	☐	☐	☐	☐

Vaccination information

Dose 1 ___/___/___

Dose 2 ___/___/___

Dose 3 ___/___/___

HBIG ___/___/___

Post vaccination serology information

Collection date ___/___/___

Lab Name _____

	Pos	Neg	Not done	unk
Total anti-HBc	☐	☐	☐	☐
HBsAg	☐	☐	☐	☐
Anti-HBs	☐	☐	☐	☐
Other labs				
IgM anti-HBc	☐	☐	☐	☐
HBV DNA (PCR)	☐	☐	☐	☐
HBeAg	☐	☐	☐	☐

Date closed to case management: ____/____/___

Reason case management complete

☐ Services completed ☐ Lost to follow up ☐ Refused services

☐ Moved out of country ☐ Moved out of state ☐ Transferred out of state

☐ Household chronic carrier

ADMINISTRATION JUNE 2018

Remember to copy mother's name to the top of this page.

Case report sent to OHA on ____/____/____

Completed by _____ Date _____ Phone _____ Investigation sent to OHA on ____/____/____