



Contact Case Management Report
Perinatal Hepatitis B Prevention Program
 Infectious Disease Intervention and Control Branch
 Texas Department of State Health Services
 PO Box 149347/ Mail code 1939
 Austin, Texas 78714-9347
 FAX: (512) 458-7787 PHONE: (512) 458-7447

Contact's Information:

Initial Report Date: ___/___/___ (mm/dd/yyyy) ID#: ___/___/___/___ (yr /county/mother/ hh#)

Last Name: _____ First Name: _____

DOB: ___/___/___ Gender: Female Male

First Name of Index Case: _____ Last Name of Index Case: _____ DOB: ___/___/___

Relationship to Index Case: _____

Address: _____ City: _____ Zip: _____ County: _____

Home Phone: ___/___-___-___ Work Phone: ___/___-___-___ Medicaid #: _____ SS#: - -

Race/Ethnicity: _____ Country of Birth: _____

Language Spoken: _____ Language Written: _____

Alternate Contact Information: _____

Contact's Provider Information:

Doctor's Name: _____ Phone: ___/___-___-___ Fax: ___/___-___-___

Address: _____ City: _____ Zip: _____

Contact's Hepatitis B Serology and Vaccination History:

Prior hepatitis B serology test? No Yes (If yes indicate lab results)

Prior report HBsAg: Reactive Non Reactive Date: ___/___/___

Prior report anti-HBs: Reactive Non Reactive Date: ___/___/___

Prior report anti-HBc: Reactive Non Reactive Date: ___/___/___

Prior hepatitis B vaccination history? No If Yes Dates: _____, _____, _____

HBIG at Birth: Yes No

Results of Serology Tests for the Contact Performed After Initial Report Date:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor /Clinic)
HBsAg	___/___/___			
Anti-HBs	___/___/___			
Anti-HBc	___/___/___			

Hepatitis B Vaccine Record for the Contact – Series 1 Given After Initial Report Date:

Series 1	Date	Dose	Formulation	Manufacturer	Lot Number	Provider(Doctor/Clinic)
1 st Hep B dose	___/___/___					
2 nd Hep B dose	___/___/___					
3 rd Hep B dose	___/___/___					

Results of Post Vaccine Serology for the Contact – Series 1

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
HBsAg	___/___/___			
Anti-HBs	___/___/___			
Anti-HBc	___/___/___			

Hepatitis B Vaccine Record for the Contact – Series 2: Complete Series 2 – IF CONTACT DID NOT SEROCONVERT AFTER SERIES 1

Series 2	Date	Dose	Formulation	Manufacturer	Lot Number	Provider (Doctor/Clinic)
1 st Hep B dose	___/___/___					
2 nd Hep B dose	___/___/___					
3 rd Hep B dose	___/___/___					

Results of Post Vaccine Serology for the Contact – Series 2:

Type of Test	Test Date	Result	Reporter (Lab)	Provider (Doctor/Clinic)
HBsAg	___/___/___			
Anti-HBs	___/___/___			
Anti-HBc	___/___/___			

Date Case Closed: ___/___/___ Reason Closed: _____ Status: _____

