



Texas Department of State Health Services
Perinatal Hepatitis B Prevention Program
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Perinatal Hepatitis B Prevention Program Supplemental Information Form

Index Case ID#: _____
yr /county/mother/ hh#

Index Case: Last Name: _____ First Name: _____

Maternal Grandmother Country of Birth: _____

Mother HBV DNA Viral Load: Yes Result: _____ Date: _____
N/A

Mother being monitored for hepatitis B by a physician? Yes No

Mother treated for hepatitis B for this pregnancy? Yes No

If yes, treatment start date: _____

Antiviral treatment: Yes No

If yes, brand: _____ dose: _____

Is mother a chronic carrier? Yes No

If yes, did a local or regional health department refer mother to a health care provider for medical follow-up? Yes No

Does mother have other infections/conditions? Hep C HIV Syphilis

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