



**Infant 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  
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**Infant's Information:**

Initial Report Date: \_\_\_/\_\_\_/\_\_\_  
(mm/dd/yyyy)

ID#: \_\_\_/\_\_\_/\_\_\_/\_\_\_  
(yr /county/mother/ hh#)

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Gender: Female  Male  Birth Weight <2,000 grams: Yes  No

Mother First Name: \_\_\_\_\_ Mother Last Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_/\_\_\_-\_\_\_-\_\_\_ Work Phone: \_\_\_/\_\_\_-\_\_\_-\_\_\_ Medicaid #: \_\_\_\_\_ SS#: - -

Race/Ethnicity: \_\_\_\_\_ Delivery Hospital: \_\_\_\_\_

Alternate Contact Information: \_\_\_\_\_

**Infant's Provider Information:**

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_/\_\_\_-\_\_\_-\_\_\_ Fax: \_\_\_/\_\_\_-\_\_\_-\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**HBIG and Hepatitis B Vaccine Record – Series 1:**

Series 1	Date	Dose	Formulation	Manufacturer	Lot Number	Provider (Doctor/Clinic)
HBIG	/ /					
1 <sup>st</sup> Hep B dose	/ /					
2 <sup>nd</sup> Hep B dose	/ /					
3 <sup>rd</sup> Hep B dose	/ /					
4 <sup>th</sup> Hep B dose	/ /					

**Results of Post Vaccine Serology – Series 1: Complete PVS 3 months after final dose of Hepatitis B vaccine series**

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

**Hepatitis B Vaccine Record – Series 2: Complete Series 2 - IF INFANT DID NOT SEROCONVERT AFTER SERIES 1**

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

**Results of Post Vaccine Serology – Series 2:**

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

**\*If Lost to Follow-up or Non Compliant, please obtain vaccination and/or PVS record history from:**

Immtrac: Yes  No

Pediatric Health Care Provider: Yes  No

**Infant's Closure Information:**

Date Case Closed: \_\_\_/\_\_\_/\_\_\_

Reason Closed: \_\_\_\_\_

Status: \_\_\_\_\_