Louisiana Department of Health
Office of Public Health
PERINATAL HEPATITIS B SURVEILLANCE FORM

Case#__________

SECTION I: PRENATAL CARE
Part A: Mother Information

1. Last Name ______________________ 2. First Name ______________________

3. Address ______________________ Address #2 ______________________

4. City ______________ 5. Zip ______________ 6. Parish ______________

7. Phone ______________________ Alternate Phone ______________________

8. Age _____ 9. Date of Birth ___/___/___ (mo day yr) 10. Primary language ______________________

11. Race (check): ☐White ☐Black ☐Asian/Pacific Islander ☐Other ______________ 12. Ethnicity: ☐Hispanic ☐Non-Hispanic

Part B: Medical Information (Mother)

1. Prenatal care received? ☐Yes ☐No 2. Health Insurance Status: ☐Medicaid ☐Private Insurance ☐Other ______________

3. Name of prenatal care provider/clinic name ______________________ 4. Clinic Phone # ______________________
Clinic Fax # ______________________

5. Date hepatitis B labs collected ___/___/___ (mo day yr)

HBsAg test result (during this pregnancy) ☐Pos ☐Neg
PLEASE ATTACH A COPY OF THE PATIENT'S HEPATITIS B LAB RESULTS (including HBsAg and HBV DNA)

6. Expected delivery date ___/___/___ (mo day yr)

7. Expected hospital of delivery ______________________

SECTION II: DELIVERY HOSPITAL CARE
Part A: Mother

1. Pregnancy outcome ☐ live birth ☐ stillborn ☐ miscarriage ☐pregnancy terminated

2. Hospital of delivery ______________________

Part B: Infant

1. Last Name ______________________ 2. First Name ______________________

3. Date of Birth ___/___/___ (mo day yr) 4. Birth time ___:___ (hr mn) am/pm 5. Birth weight ___________

6. Sex Female ☐ Male ☐ 7. Health Insurance Status at Birth: ☐Medicaid ☐Private Insurance ☐Other ______________

8. HBIG date ___/___/___ (mo day yr) HBIG time ___:___ (hr mn) am/pm

9. 1st dose HepB vaccine date ___/___/___ (mo day yr) 1st dose HepB vaccine time ___:___ (hr mn) am/pm

10. Name of pediatrician/clinic name ______________________ 11. Clinic Phone # ______________________
Clinic Fax # ______________________

Please fax or mail form to:
Louisiana Department of Health
Office of Public Health-Immunization Program
Attn: Hepatitis Program Manager
(504) 568-2600
(504) 568-2659 fax

For Office Use Only:

SECTION III: INFANT'S VACCINE RECORD

Part A: HBIG

1. HBIG date ____/____/_____ (mo day yr) HBIG time ____:____ (hr mn) am/pm

Part B: Hepatitis B Vaccine

1. Dose #1 ____/____/_____ (mo day yr) Dose #2 ____/____/_____ (mo day yr) Dose #3 ____/____/_____ (mo day yr)

2. Additional Dose of Hepatitis B Vaccine (if indicated) Explain ____

   Dose #4 ____/____/_____ (mo day yr) Dose #5 ____/____/_____ (mo day yr) Dose #6 ____/____/_____ (mo day yr)

Part C: Infant's 9-12 months Follow-up Serology:

1. Date ____/____/_____ (mo day yr)

   HBsAg ☐Pos ☐Neg ☐Not done
   anti-HBs ☐Pos ☐Neg ☐Not done Quantitative value __________ mIU/mL

2. Repeat Serology (if needed)

   Date ____/____/_____ (mo day yr)

   HBsAg ☐Pos ☐Neg ☐Not done
   anti-HBs ☐Pos ☐Neg ☐Not done Quantitative value __________ mIU/mL

Section IV: CASE DISPOSITION

1. Date ____/____/_____ (mo day yr)

   ☐Case completed
   ☐Lost to follow-up/ unable to locate
   ☐Parent/guardian non-compliant
   ☐Provider non-compliant
   ☐Transfer out of state

   Initials of person closing case __________

(Rev 03/19)