State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
850 Marina Bay Parkway Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (510) 620-3949

PERINATAL HEPATITIS B CASE REPORT FORM

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information

Work / School Location	Work / School Contact

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)

Medical Record Number	Patient's Parent/Guardian Name

Occupation Setting (see list on page 12)	Other Describe/Specify

Occupation (see list on page 12)	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 7)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.
☐ American Indian or Alaska Native
☐ Asian (check all that apply, see list on page 7)
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
(check all that apply, see list on page 7)
- ☐ Native Hawaiian
- ☐ Fijian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tongan
- ☐ Other: _____

☐ White
☐ Other: _____
☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

CLINICAL INFORMATION

Instructions

This form is to be used for infants aged 1-24 months found to be infected with hepatitis B virus

REASONS FOR TESTING

☐ Postvaccination serologic testing	☐ Evaluation of liver enzymes	☐ Symptoms of acute hepatitis	☐ Unknown	☐ Other	If Other, specify:
Was infant enrolled in California's Perinatal Hep B Prevention Program? ☐ Yes ☐ No	If No, specify why not enrolled?		If Yes, specify PHPP ID		

SIGNS AND SYMPTOMS

Symptomatic?

☐ Yes ☐ No ☐ Unknown

SYMPTOMS

☐ Jaundice	☐ Dark Urine	☐ Diarrhea	☐ Anorexia	☐ Abdominal Pain	☐ Clay stools
☐ Fever	☐ Headache	☐ Nausea	☐ Vomiting	☐ Other	If Other, specify

BIRTH FACILITY

Was patient born in a hospital, birth center or other facility?

☐ Yes ☐ No ☐ Unknown

Birth Facility – Details

Birth Facility Name	Street Address	
City	State ZIP Code	Telephone #

HOSPITALIZATION

Hospitalized? ☐ Yes ☐ No ☐ Unknown	Days Hospitalized		
ICU Admission ☐ Yes ☐ No ☐ Unknown			
Hospital Name	Street Address		
City	State	ZIP Code	Telephone
Admit Date (mm/dd/yyyy)	Discharge / Transfer Date (mm/dd/yyyy)		
Medical Record Number	Discharge Diagnosis		

COMPLICATIONS AND OTHER SYMPTOMS	
Did patient develop fulminant hepatitis B? ☐ Yes ☐ No ☐ Unknown	Did patient die? ☐ Yes ☐ No ☐ Unknown
If patient died, date of death (mm/dd/yyyy)	

VACCINATION HISTORY		
Did this patient receive HBIG? ☐ Yes ☐ No ☐ Unknown	Date (mm/dd/yyyy)	Age in hours HBIG received (if less than or equal to 24)
Dose #1 ☐ Yes ☐ No ☐ Unknown	Date (mm/dd/yyyy)	Age in hours dose #1 received (if less than or equal to 24)
Dose #2 ☐ Yes ☐ No ☐ Unknown	Date (mm/dd/yyyy)	
Dose #3 ☐ Yes ☐ No ☐ Unknown	Date (mm/dd/yyyy)	
Dose #4 (if applicable) ☐ Yes ☐ No ☐ Unknown	Date (mm/dd/yyyy)	
Comments		

LABORATORY INFO	
Hepatitis B Diagnostic Tests	
HBsAg Date (mm/dd/yyyy)	HBsAg Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Anti-HBs Date (mm/dd/yyyy)	Anti-HBs Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Anti-HBc Total Date (mm/dd/yyyy)	Anti-HBc Total Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Anti-HBc IgM Date (mm/dd/yyyy)	Anti-HBc IgM Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
HBV DNA (Quant.) Date (mm/dd/yyyy)	HBV DNA Result (IU/ml)
HBV DNA (Qual.) Date (mm/dd/yyyy)	HBV DNA Result (Qual) ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
HBeAg Date (mm/dd/yyyy)	HBeAg Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Anti-HBe Date (mm/dd/yyyy)	Anti-HBe Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Other Lab Test Performed	
Other Lab Test Date (mm/dd/yyyy)	Other Lab Test Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

LIVER ENZYME LEVELS AT DIAGNOSIS		
Alanine Transaminase [Serum Glutamic Pyruvic Transaminase] (ALT [SGPT]) date	ALT [SGPT] result	Upper Limit Normal
Aspartate Aminotransferase [Serum Glutamic Oxaloacetic Transaminase] (AST [SGOT]) date	AST [SGOT] result	Upper Limit Normal
Bilirubin Date (mm/dd/yyyy)	Bilirubin Result	

EPIDEMIOLOGIC INFO	
Mother's Information	
Mother's Ethnicity	Mother's Race
Mother's Country of Birth	If Other, Specify
Was mother confirmed HBsAg-positive PRIOR TO or AT delivery? ☐ Yes ☐ No ☐ Unknown	Was mother confirmed HBsAg-positive AFTER delivery? ☐ Yes ☐ No ☐ Unknown

MOTHER'S HEPATITIS B DIAGNOSTIC TESTS	
HBsAg Date (mm/dd/yyyy)	HBsAg Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
HBeAg Date (mm/dd/yyyy)	HBeAg Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Anti-HBe Date (mm/dd/yyyy)	Anti-HBe Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
HBV DNA Date (mm/dd/yyyy)	HBV DNA Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Other Lab Test Performed ☐ Yes ☐ No ☐ Unknown	If Yes, Specify
Other Lab Test Date (mm/dd/yyyy)	Other Lab Test Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline
Did mother receive antiviral treatment (e.g., lamivudine) or HBIG during pregnancy? ☐ Yes ☐ No ☐ Unknown	Type of Treatment

CONTACTS		
Relationship	Hepatitis B Status ☐ Immune ☐ Infected ☐ Susceptible ☐ Unknown	Seroscreened for HBV infection or immunity? ☐ Yes ☐ No ☐ Unknown
Vaccination History	Vaccine Administered as Post-Exposure Prophylaxis ☐ Yes ☐ No ☐ Unknown	
HBIG Administered as Post-Exposure Prophylaxis ☐ Yes ☐ No ☐ Unknown	Reason PEP Not Given	
Notes		Perinatal HBV Prevention Program (PHPP) ID (if applicable)

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CASE DEFINITION

HBsAg positivity in any infant aged > 1-24 months who was born in the United States or in U.S. territories to an HBsAg-positive mother

POSTEXPOSURE PROPHYLAXIS

All infants born to HBsAg-positive mothers should receive hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine within 12 hours of birth, followed by the second and third doses of vaccine at 1 and 6 months of age, respectively.

POSTVACCINATION SEROLOGIC TESTING

Testing for anti-HBs and HBsAg should be performed after completion of the vaccine series (or 3rd dose), at age 9—18 months.

Investigator Name (print)	Telephone Number
Agency Name	
Date (mm/dd/yyyy)	

RACE DESCRIPTIONS	
Race	**Description**
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS				
Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS				
Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	