

Perinatal Hepatitis B Household Contact Follow-up Report



Minnesota Department of Health
 Immunization, Tuberculosis, and International Health Section
 625 Robert St N, PO Box 64975, St. Paul, MN 55164-0975
 For information call: 651-201-5557

Tennessee Warning _____
 initials

Mother's name: *(index case)* _____ Mother's DOB: _____ MDH Record No.: _____

Infant's maternal grandmother's country of birth: _____

Submitted by (name): _____ Agency: _____ Date completed: _____

Contact's name: _____ Birth date: _____ Gender: _____ Contact type: Sexual Household IDU

Relationship to index: Spouse Partner Son Daughter Brother Sister Father Mother Uncle Aunt
 Nephew Niece Cousin In-law Stepfather Stepmother Stepchild Other

Address: _____ City: _____ Zip: _____

Race: _____ Ethnicity: _____

<i>Pre-vaccination Testing</i>	<i>Immunization: 1st Series</i>	<i>Post-vaccination Testing</i>	<i>Immunization: 2nd Series (non-responders only)</i>	<i>Post-vaccination Testing</i>
Refused?: _____	Refused?: _____	Refused?: _____	Refused?: _____	Refused?: _____
HBsAG date: _____	HBIG date: _____	HBsAG date: _____	HBV1 date: _____	HBsAG date: _____
Result: _____	HBV1 date: _____	Result: _____	HBV2 date: _____	Result: _____
Anti-HBs date: _____	HBV2 date: _____	Anti-HBs date: _____	HBV3 date: _____	Anti-HBs date: _____
Result: _____	HBV3 date: _____	Result: _____		Result: _____
HBcAb date: _____	HBV4 date: _____	HBcAb date: _____		HBcAb date: _____
Result: _____		Result: _____		Result: _____

Comments: _____