



Perinatal Hepatitis B Household Contact Follow-up Report

Date: ___/___/___ *Tennessee Warning* _____ (Initials)
 Mother's First Name _____ Last Name _____ Mother's DOB: ___/___/___ Legacy ID: _____
 Submitted by (name): _____ Agency: _____ Date completed: ___/___/___

First name: _____ Last name: _____ DOB: ___/___/___ Gender: _____					
Street Address: _____ City: _____ Zip: _____ <input type="checkbox"/> Same as Mother					
Contact Type: <input type="checkbox"/> Sexual Contact <input type="checkbox"/> Biological child (<6 years old) <input type="checkbox"/> Non-biological child (<6 years old) <input type="checkbox"/> Needle-sharing contact					
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black African American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown Country of birth: _____		
Primary Contact	Pre-vaccination Testing	Immunization: 1st Series	Post-vaccination Testing	Immunization: 2nd Series (non-responders only)	Post-vaccination (2nd) Testing
	Refused?: _____	Refused?: _____	Refused?: _____	Refused?: _____	Refused?: _____
	HBsAg date: ___/___/___	HBIG date: ___/___/___	HBsAg date: ___/___/___	Refused?: _____	HBsAg date: ___/___/___
	HBsAg Result: _____	HBV1 date: ___/___/___	HBsAg Result: _____	HBV1 date: ___/___/___	HBsAg Result: _____
	Anti-HBs date: ___/___/___	HBV2 date: ___/___/___	Anti-HBs date: ___/___/___	HBV2 date: ___/___/___	Anti-HBs date: ___/___/___
	Anti-HBs result: _____	HBV3 date: ___/___/___	Anti-HBs result: _____	HBV3 date: ___/___/___	Anti-HBs result: _____
	Anti-HBc date: ___/___/___	HBV4 date: ___/___/___	Anti-HBc date: ___/___/___		Anti-HBc date: ___/___/___
Anti-HBc result: _____		Anti-HBc result: _____		Anti-HBc result: _____	

Other Household Contacts	Name: _____ DOB: ___/___/___ Gender: _____ Relationship to index: _____	<input type="checkbox"/> Recommendation <input type="checkbox"/> Sent resources
	Name: _____ DOB: ___/___/___ Gender: _____ Relationship to index: _____	<input type="checkbox"/> Recommendation <input type="checkbox"/> Sent resources
	Name: _____ DOB: ___/___/___ Gender: _____ Relationship to index: _____	<input type="checkbox"/> Recommendation <input type="checkbox"/> Sent resources
	Name: _____ DOB: ___/___/___ Gender: _____ Relationship to index: _____	<input type="checkbox"/> Recommendation <input type="checkbox"/> Sent resources
	Name: _____ DOB: ___/___/___ Gender: _____ Relationship to index: _____	<input type="checkbox"/> Recommendation <input type="checkbox"/> Sent resources
	Name: _____ DOB: ___/___/___ Gender: _____ Relationship to index: _____	<input type="checkbox"/> Recommendation <input type="checkbox"/> Sent resources

Comments: