IOWA Health and Human Services

Bureau of Immunization and TB
Perinatal Hepatitis B Carrier Follow-Up Report

This form is designed to facilitate the follow-up of a Perinatal Hepatitis B case. Review the Perinatal Hepatitis B Prevention Program Guide for additional information. Please complete and fax to 1-800-831-6292. Questions may be directed to Shelly Jensen, RN, BSN Perinatal Hepatitis B Coordinator 1-800-831-6293 extension 1 or Shelly.Jensen@hhs.iowa.gov

Person Completing Form: _____ Date Faxed/Sent: _____

Phone Number: _____ Email: _____ County: _____

I. Mother - Screening Data

Mother's Name:(First)_____ (Last)_____DOB: _____
Address:_____ City/State/Zip:_____
County: _____ Phone: _____

Following Physician: _____ Phone: _____
Clinic Name: _____ Fax: _____
Clinic Address: _____ City/State/Zip: _____

Race/Ethnicity

☐ Asian/Pacific Islander
☐ American Indian/ Alaskan Native
☐ Black/ African American
☐ Unknown
☐ Hispanic/ Latino
☐ White
☐ Other: _____

Country of Birth

Is the client foreign born? ☐Yes ☐No If yes, country of origin: _____
Is the client English speaking? ☐Yes ☐No If no, indicate language spoken: _____

Delivery Information

Anticipated Date of Delivery: _____
Anticipated Delivery Hospital: _____ Phone: _____
Address: _____ City/State/Zip: _____

Hepatitis B Testing

Was mother tested for HBsAg? ☐Yes ☐ No If Yes, date tested: _____
Test conducted: ☐Pre-Pregnancy ☐1st Trimester ☐2nd Trimester ☐3rd Trimester ☐At Delivery
HBsAg test Results: ☐Positive ☐Negative

Was mother tested for HBV DNA? ☐Yes ☐ No If Yes, date tested: _____
HBV DNA Level: _____
Is mother on maternal antiviral therapy? ☐Yes ☐ No If Yes list medication and dosage: _____

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II. Infant Follow Up - Immunization/Prophylaxis

Complete separate forms for multiple births.

Infant Name: (First) _____ (Last) _____ Sex: ☐Female ☐Male
Date and Time of Birth: _____ Birth Weight: _____

Race/Ethnicity

☐ Asian/Pacific Islander
☐ American Indian/ Alaskan Native
☐ Black/ African American
☐ Unknown
☐ Hispanic/ Latino
☐ White
☐ Other: _____

Hepatitis B Immune Globulin (HBIG)

Date HBIG Administered: Date: _____ Time: _____
Administered within 12 hours of birth? ☐Yes ☐No

Hepatitis B Vaccine (HBV)

Date HBV dose 1 Administered: Date: _____ Time: _____
Administered within 12 hours of birth? ☐Yes ☐No

Date HBV Administered: Dose 2: _____ Dose 3: _____ Dose 4: _____
Vaccine recorded in IRIS: ☐Yes ☐No

Infant's Physician: _____ Phone: _____
Clinic Name: _____ Fax: _____
Clinic Address: _____ City/State/Zip: _____
**If needed, the Department can supply the Hepatitis B vaccine and Hepatitis B Immune Globulin for the baby.

III. Infant - Post-Vaccination Serology

Testing recommended at age 9-12 months; at least 1-2 months following completion of the Hepatitis B vaccine series.
DO NOT test prior to age 9 months of age.

HBsAg Testing Date: _____☐Positive ☐Negative ☐Not Tested
Anti-HBs Testing Date: _____ ☐Positive ☐Negative Value: _____ ☐Not Tested
Immune: ☐Yes ☐No