PERINATAL HEPATITIS B CASE INVESTIGATION - Page 1 of 2

Indiana State Department of Health
State Form 52589 (2-06)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / /

Country of birth:

◯ United States ◯ Other, specify:

Section 2. Maternal Risk Factors

Race:

◯ Asian
◯ Black or African American
◯ American Indian or Alaska Native
◯ Native Hawaiian or Other Pacific Islander
◯ White
◯ Other/Multiracial
◯ Unknown

Ethnicity:

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown

Was the mother born outside the United States?

◯ Yes ◯ No ◯ Unknown

If Yes, what country?

Was the mother confirmed HBsAg positive prior to or at time of delivery?

◯ Yes ◯ No ◯ Unknown

If No, was the mother confirmed HBsAg positive after delivery?

◯ Yes ◯ No ◯ Unknown

Date of HBsAg positive test result:

/ /

Section 3. Immune Globulin and Child Vaccine Information

Did the child receive hepatitis B immune globulin (HBIG)?

◯ Yes ◯ No ◯ Unknown

If Yes, on what date did the child receive HBIG?

/ /

Was HBIG given within 12 hours of birth?

◯ Yes ◯ No ◯ Unknown

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Section 3. Immune Globulin and Child Vaccine Information (continued)

Did the child receive hepatitis B vaccine?

○ Yes ○ No ○ Unknown

If Yes, list the dates of doses received:

__/__/__ Dose 1 __/__/__ Dose 2 __/__/__ Dose 3

Was dose 1 given within 12 hours of birth?

○ Yes ○ No ○ Unknown

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

___-___-____ **Phone Number** __/__/__ **Date**