



## **SUPPLEMENT #2**

# **HEPATITIS B IN PREGNANT WOMAN**

*For assistance filling out this form, call (617) 983-6800*

### **ADMINISTRATIVE INFORMATION**

Investigator's name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Agency: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Date first reported to you: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date investigation started: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date form completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **DEMOGRAPHIC INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Was the case previously reported to the state health department? ☐ Yes ☐ No ☐ Unk

If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_

*If available, attach any additional laboratory results from previous reports*

**CONTACT THE MASSACHUSETTS IMMUNIZATION PROGRAM PERINATAL HEPATITIS B NURSE AT (617) 983-6800**

Expected delivery date: \_\_\_\_/\_\_\_\_/\_\_\_\_

OB name and address: \_\_\_\_\_

Planned location of delivery: \_\_\_\_\_ OB phone number: (\_\_\_\_) \_\_\_\_/\_\_\_\_

### **VACCINE INFORMATION**

Immune to hepatitis B virus confirmed by laboratory testing? ☐ Yes ☐ No ☐ Unk

3 doses of hepatitis B vaccine (series complete) ☐ Yes ☐ No ☐ Unk

2 doses of hepatitis B vaccine (1 dose due) ☐ Yes ☐ No ☐ Unk

1 dose of hepatitis B vaccine (2 doses due) ☐ Yes ☐ No ☐ Unk

0 doses of hepatitis B vaccine (3 doses due) ☐ Yes ☐ No ☐ Unk

If yes, specify:

	<b>Dose 1</b>	<b>Dose 2</b>	<b>Dose 3</b>
Date:	____/____/____	____/____/____	____/____/____

Type/Manuf:	_____	_____	_____
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Lot #:	_____	_____	_____
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**PLEASE FILL OUT THE FOLLOWING PAGE(S) FOR SEXUAL AND HOUSEHOLD  
CONTACTS OF THE HBsAg+ PREGNANT WOMAN**

**CONTACT INFORMATION – IF THERE ARE MORE THAN 2 CONTACTS, PLEASE COPY THIS PAGE  
AND ATTACH WITH CASE REPORT FORM**Contact #1

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: ☐ Female ☐ Male ☐ Other ☐ Unk

Race (check all that apply): (Optional)

☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ UnkHispanic (Optional): ☐ Yes ☐ No ☐ Unk

Relationship to HBsAg+ pregnant woman: \_\_\_\_\_

Date of HBIG: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of hepatitis B vaccine:

**Dose 1****Dose 2****Dose 3**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Type/Manuf: \_\_\_\_\_

Lot #: \_\_\_\_\_

Date and result of contact's HBsAg serologic test:

☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (specify): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date and result of contact's anti-HBs serologic test:

☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (specify): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_Contact #2

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: ☐ Female ☐ Male ☐ Other ☐ Unk

Race (check all that apply): (Optional)

☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ UnkHispanic (Optional): ☐ Yes ☐ No ☐ Unk

Relationship to HBsAg+ pregnant woman: \_\_\_\_\_

Date of HBIG: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of hepatitis B vaccine:

**Dose 1****Dose 2****Dose 3**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Type/Manuf: \_\_\_\_\_

Lot #: \_\_\_\_\_

Date and result of contact's HBsAg serologic test:

☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (specify): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date and result of contact's anti-HBs serologic test:

☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (specify): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**MAKE COPIES OF THIS PAGE FOR ADDITIONAL CONTACTS**