



Hepatitis B, Pregnancy Event Supplemental Reporting Form

INTERVIEW

EpiTrax # _____ Interviewer Name: _____

Number of Call Attempts: _____ Follow-up Status: Interviewed Refused Interview Lost to Follow-Up*

Date of Interview (must enter MM/DD/YYYY): _____

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

Respondent was: Self Parent Spouse Other, *Specify*: _____

DEMOGRAPHICS

County: _____ Birth Gender: Male Female Date of Birth: _____ Age: _____

Hispanic/Latino Origin: Yes No Unknown

Race: White Black/African American American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander
 Other _____ Unknown

Insurance Type: Private Medicaid Uninsured Other, *Specify*: _____

CLINICAL

<p>Are you pregnant?</p> <ul style="list-style-type: none"> • If yes, expected delivery date <ul style="list-style-type: none"> ○ Hospital Notified • Expected delivery facility • Place type • Phone 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>_____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>_____</p> <p><input type="checkbox"/> Hospital/ICP <input type="checkbox"/> Clinic/Doctor's Office</p> <p><input type="checkbox"/> Other, specify: _____</p>
<ul style="list-style-type: none"> ○ Actual delivery date ○ Actual delivery facility ○ Place type ○ Phone 	<p>_____</p> <p>_____</p> <p><input type="checkbox"/> Hospital/ICP <input type="checkbox"/> Clinic/Doctor's Office</p> <p><input type="checkbox"/> Other, specify: _____</p>

CONTACTS

All household members, including children, should be included as contacts.

Number of previous births: _____

Contact 1 Name:	Disposition:	Disposition date:	Contact type:
	<input type="checkbox"/> Active Follow-up <input type="checkbox"/> Completed <input type="checkbox"/> Provider refusal <input type="checkbox"/> Mother/family refusal <input type="checkbox"/> Moved <input type="checkbox"/> Unable to locate <input type="checkbox"/> Adopted <input type="checkbox"/> Died <input type="checkbox"/> False positive mother/case <input type="checkbox"/> Miscarriage/termination <input type="checkbox"/> Other		<input type="checkbox"/> Infant <input type="checkbox"/> Adult household <input type="checkbox"/> Child by case mother <input type="checkbox"/> Child by other mother <input type="checkbox"/> Non-spouse sexual contact <input type="checkbox"/> Spouse sexual contact
Contact 1 Clinical			
Was screening performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Time HBIG Given:		Time HepB1 Given:	
Was post-vaccination serological testing performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pediatrician notified of mom's HBsAg status?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact 1 Laboratory			
Hepatitis B surface antigen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Hepatitis B surface antigen	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Contact 2 Name:	Disposition:	Disposition date:	Contact type:
	<input type="checkbox"/> Active Follow-up <input type="checkbox"/> Completed <input type="checkbox"/> Provider refusal <input type="checkbox"/> Mother/family refusal <input type="checkbox"/> Moved <input type="checkbox"/> Unable to locate <input type="checkbox"/> Adopted <input type="checkbox"/> Died <input type="checkbox"/> False positive mother/case <input type="checkbox"/> Miscarriage/termination <input type="checkbox"/> Other		<input type="checkbox"/> Infant <input type="checkbox"/> Adult household <input type="checkbox"/> Child by case mother <input type="checkbox"/> Child by other mother <input type="checkbox"/> Non-spouse sexual contact <input type="checkbox"/> Spouse sexual contact
Contact 2 Clinical			
Was screening performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Time HBIG Given:		Time HepB1 Given:	
Was post-vaccination serological testing performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pediatrician notified of mom's HBsAg status?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact 2 Laboratory			
Hepatitis B surface antigen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Hepatitis B surface antigen	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested

Contact 3 Name:	Disposition:	Disposition date:	Contact type:
	<input type="checkbox"/> Active Follow-up <input type="checkbox"/> Completed <input type="checkbox"/> Provider refusal <input type="checkbox"/> Mother/family refusal <input type="checkbox"/> Moved <input type="checkbox"/> Unable to locate <input type="checkbox"/> Adopted <input type="checkbox"/> Died <input type="checkbox"/> False positive mother/case <input type="checkbox"/> Miscarriage/termination <input type="checkbox"/> Other		<input type="checkbox"/> Infant <input type="checkbox"/> Adult household <input type="checkbox"/> Child by case mother <input type="checkbox"/> Child by other mother <input type="checkbox"/> Non-spouse sexual contact <input type="checkbox"/> Spouse sexual contact
Contact 3 Clinical			
Was screening performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Time HBIG Given:		Time HepB1 Given:	
Was post-vaccination serological testing performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pediatrician notified of mom's HBsAg status?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact 3 Laboratory			
Hepatitis B surface antigen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Hepatitis B surface antigen	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Contact 4 Name:	Disposition:	Disposition date:	Contact type:
	<input type="checkbox"/> Active Follow-up <input type="checkbox"/> Completed <input type="checkbox"/> Provider refusal <input type="checkbox"/> Mother/family refusal <input type="checkbox"/> Moved <input type="checkbox"/> Unable to locate <input type="checkbox"/> Adopted <input type="checkbox"/> Died <input type="checkbox"/> False positive mother/case <input type="checkbox"/> Miscarriage/termination <input type="checkbox"/> Other		<input type="checkbox"/> Infant <input type="checkbox"/> Adult household <input type="checkbox"/> Child by case mother <input type="checkbox"/> Child by other mother <input type="checkbox"/> Non-spouse sexual contact <input type="checkbox"/> Spouse sexual contact
Contact 4 Clinical			
Was screening performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Time HBIG Given:		Time HepB1 Given:	
Was post-vaccination serological testing performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pediatrician notified of mom's HBsAg status?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact 4 Laboratory			
Hepatitis B surface antigen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Hepatitis B surface antigen	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested

Contact 5 Name:	Disposition:	Disposition date:	Contact type:
	<input type="checkbox"/> Active Follow-up <input type="checkbox"/> Completed <input type="checkbox"/> Provider refusal <input type="checkbox"/> Mother/family refusal <input type="checkbox"/> Moved <input type="checkbox"/> Unable to locate <input type="checkbox"/> Adopted <input type="checkbox"/> Died <input type="checkbox"/> False positive mother/case <input type="checkbox"/> Miscarriage/termination <input type="checkbox"/> Other		<input type="checkbox"/> Infant <input type="checkbox"/> Adult household <input type="checkbox"/> Child by case mother <input type="checkbox"/> Child by other mother <input type="checkbox"/> Non-spouse sexual contact <input type="checkbox"/> Spouse sexual contact
Contact 5 Clinical			
Was screening performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Time HBIG Given:		Time HepB1 Given:	
Was post-vaccination serological testing performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pediatrician notified of mom's HBsAg status?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact 5 Laboratory			
Hepatitis B surface antigen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Hepatitis B surface antigen	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Contact 6 Name:	Disposition:	Disposition date:	Contact type:
	<input type="checkbox"/> Active Follow-up <input type="checkbox"/> Completed <input type="checkbox"/> Provider refusal <input type="checkbox"/> Mother/family refusal <input type="checkbox"/> Moved <input type="checkbox"/> Unable to locate <input type="checkbox"/> Adopted <input type="checkbox"/> Died <input type="checkbox"/> False positive mother/case <input type="checkbox"/> Miscarriage/termination <input type="checkbox"/> Other		<input type="checkbox"/> Infant <input type="checkbox"/> Adult household <input type="checkbox"/> Child by case mother <input type="checkbox"/> Child by other mother <input type="checkbox"/> Non-spouse sexual contact <input type="checkbox"/> Spouse sexual contact
Contact 6 Clinical			
Was screening performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Time HBIG Given:		Time HepB1 Given:	
Was post-vaccination serological testing performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pediatrician notified of mom's HBsAg status?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Contact 6 Laboratory			
Hepatitis B surface antigen:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested
Hepatitis B surface antigen	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested	Hepatitis B Surface Antibody Total (anti-HBs)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested