LHD PERINATAL HEPATITIS B CASE ROSTER

Health District Jurisdiction: _____ PHBPP Nurse Name & Phone: _____

Mother ODRS Case#: _____ Address: _____

Case Phone #: _____ LHD Initial Contact Date: _____ Closed Date: _____

Case DOB: _____ Country of Birth: _____ Living Household Children: _____ Partner Name: _____

EDD (due date): _____ Obstetrician/PCP: _____ Mother Prenatal HBsAG Date/Results: _____

Infants Name Or Pregnancy Gestation	**DOB**	**Sex**	**Infant ODRS#**	**Peds/PCP Name Telephone**	**Birth Weight**	**Birthing Facility**	**HBIG Date**	**Vaccine #1 Date**	**Vaccine #2 Date**	**Vaccine #3 Date**	**Serology Date and Results**		**Other**