Perinatal Hepatitis B Contact Investigation Form

Name of Mother :	**Number:**

Contact # 1: Demographic Information and Vaccination Record

Name:			
Address:			
Phone: **( ) -**	DOB: / /	Sex:	Type of Contact:
Physician's Name:			Physician's Phone **( ) -**

date scheduled	**HBIG: / /**	**HB vax #1: / /**	**HB vax #2: / /**	**HB vax #3: / /**
date administered	**HBIG: / /**	**HB vax #1: / /**	**HB vax #2: / /**	**HB vax #3: / /**
Administrator				
Dose/Mfg/Lot#				

Contact # 2: Demographic Information and Vaccination Record

Name:			
Address:			
Phone: **( ) -**	DOB: / /	Sex:	Type of Contact:
Physician's Name:			Physician's Phone **( ) -**

date scheduled	**HBIG: / /**	**HB vax #1: / /**	**HB vax #2: / /**	**HB vax #3: / /**
date administered	**HBIG: / /**	**HB vax #1: / /**	**HB vax #2: / /**	**HB vax #3: / /**
Administrator				
Dose/Mfg/Lot#				

Contact # 3: Demographic Information and Vaccination Record

Name:			
Address:			
Phone: **( ) -**	DOB: / /	Sex:	Type of Contact:
Physician's Name:			Physician's Phone **( ) -**

date scheduled	**HBIG: / /**	**HB vax #1: / /**	**HB vax #2: / /**	**HB vax #3: / /**
date administered	**HBIG: / /**	**HB vax #1: / /**	**HB vax #2: / /**	**HB vax #3: / /**
Administrator				
Dose/Mfg/Lot#				

Use additional pages as necessary. DHMH, Center for Immunization
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