Virginia Perinatal Hepatitis B Prevention Program
Contact Information Form

Mother's Name: _____ Case Number: _____

Name	Age	Contact		Lab Results (Neg or Pos)			Vaccine for Contact		If no, please indicate reason		
		Household	Sexual	HBsAg	Anti-HBs	Anti-HBc	Yes	No	Refused	Prev. Imm	Other

Additional Comments: _____

_____

_____

Return Form To:

Virginia Department of Health
Division of Immunization
Perinatal Hepatitis B Prevention Program
P.O. Box 2448 - Room 314 - West
Richmond, Virginia 23218

12/03