Montana Perinatal Hepatitis B Prevention Program

Contact Investigation Line List

(for household, sexual, and needle sharing contacts of HBsAg pregnant women)

Case Name: _____DOB:____/____/____ County:_____ Investigation Start Date: ____/____/____

Name			Hepatitis B Vaccine/ Date Given				Serology		
Last name First name Relation to case*	DOB	HBIG Date	Dose #1	Dose #2	Dose #3	Dose #4 (if needed)	HBsAg Date/ Result	Anti-HBs Date/ Result	Date Contact Investigation Completed
_____ __*	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__ _____	__/__/__ _____	__/__/__

***Relationship to case: S-(sexual contact within last 14 day) C-(child) N-(needle sharing partner) H-(current household contact)**

Montana Immunization Program
For Questions please call 444-1805 or 444-5580
Fax (406) 444-2920
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