



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

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