

1 Case/Household Identification No. ____ - ____ - ____ (county of origin)
County mm yy

2 Case/Household Identification No. ____ - ____ - ____ (transfer county)
County mm yy

Optional worksheet (Do not send to State)

Name _____

Household address(es)/phone(s) _____

Translator needed? YES NO Mother's language _____

Staff person assigned to case/household _____ Delivery hospital _____

Provider type _____ Provider type _____

Physician name _____ Physician name _____

Clinic address(es) _____ Clinic address(es) _____

Phone(s) _____ Phone(s) _____

Infant(s) Dates Doses Due/Given=

Due
Given

Name(s)	Date of Birth	HBIG/Vac #1	Vac #2	Vac #3	Vac 4	PVS*
1.						
2.						

*Post Vaccination Serology Testing

Household Contacts Dates Doses Due/Given=

Due
Given

Name(s)	DOB	Sex	Date Referred	Serology Results	Vac #1	Vac #2	Vac #3	Notes
1.								
2.								
3.								
4.								
5.								
6.								