



HOSPITAL REPORT FOR PERINATAL HEPATITIS B PREVENTION

Follow-up of infants born to HBsAg positive mothers

Please complete the form with as much information as possible and FAX to the Perinatal Hepatitis B Prevention Program at **1-877-427-7318**.

<p>For Women Known to be HBsAg Positive:</p> <p><input type="checkbox"/> Administer hepatitis B immune globulin (HBIG) and hepatitis B vaccine within 12 hours of births to all infants.</p> <p>If the infant doesn't receive HBIG within 12 hours, it can be administered up to 7 days after birth.</p>	<p>For Women Whose HBsAg Status is Unknown:</p> <p><input type="checkbox"/> Perform a stat HBsAg screening test for all women admitted to delivery whose hepatitis B status is unknown.</p> <p><input type="checkbox"/> While test results pending, administer the hepatitis B vaccine to infant within 12 hours of birth. If the mother is discovered to be HBsAg positive then administer HBIG as soon as possible.</p>
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HOSPITAL NAME _____ CITY _____

TODAY'S DATE ____ / ____ / ____

MOTHER'S INFORMATION

Last Name:	First Name:
Date of Birth: / /	HBsAg positive test date: / /
Address:	
City:	Zip Code:
Contact Phone #: ()	Alternative Phone #: ()
OB/GYN Name:	OB/GYN Phone #: ()
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Uninsured <input type="checkbox"/> Other (please specify) _____	
Race: (check all that apply)	
<input type="checkbox"/> African American or Black	<input type="checkbox"/> Caucasian or White
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> Race, not otherwise specified
Hispanic Ethnicity:	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	

INFANT'S INFORMATION

Last Name:	First Name:
Date of Birth: / /	Time of Birth:
Date of HBIG: / /	Time of HBIG:
Date of Hepatitis B1 vaccine: / /	Time of Hepatitis B1 vaccine:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Uninsured <input type="checkbox"/> Other (please specify) _____	
Pediatrician's Name	Pediatrician's Phone #: ()
IMPORTANT: Clinic where infant will receive Hepatitis B2 vaccine: _____	
Note: Hepatitis B2 vaccine is recommended at 1month of age.	

For questions or more information please call (785) 368-8208.