Hospital Hepatitis B Reporting Form
San Bernardino County Department of Public Health Immunizations Program

Perinatal Hepatitis B Prevention Program
351 N. Mountain View Ave.
San Bernardino, Ca 92415

Phone #: 1-800-722-4794
Fax #: (909) 387-6377

Infant’s Name ___________________________ Infant’s DOB ___________ Gender ______
Infant’s Medical Record # ___________________________ Time of Birth ___________
Mother’s Name ___________________________ Mother’s DOB __________________
Mother’s Medical Record # ___________________________ Phone # __________________
Address: ________________________________________________________________

Ethnicity/Race ____________________________________________ Pre-Term ______ Term ______

Delivery Hospital

Obstetrician ___________________________ Phone # ___________________________
Pediatrician ___________________________ Phone # ___________________________

Hospital Insurance Private Medi-Cal None/Low Income Unknown

Date of Laboratory test on Mother ___ / ___ / ___ (Copies of HBsAg labs must be provided.)

HbsAg Positive Negative Not Done

Immunoprophylaxis Given to Infant:

GIVE BOTH OF THESE WITHIN 12 HOURS AFTER BIRTH

Date Given ________ Time Given ________

HBIG

___ / ___ / ___

(Specify Reason Why)

Hepatitis B Vaccine #1

___ / ___ / ___

Please check vaccine type given:

Engerix-B: 10 mcg/0.5 cc
Recombivax-HB: 5mcg/0.5 cc
Not Given (Comment Below*)

Form Completed By: ___________________________________________

Please fax to (909) 387-6377
If you have any questions please call PHPP at 1-800-722-4794

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