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 ___/___/___ ______________________ ☐ **Not Given**__________________
____
(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