Hospital Perinatal Hepatitis B Reporting Form

Immunizations Program /Perinatal Hepatitis B Prevention Program
351 N. Mt. 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