

**Perinatal Hepatitis B Prevention Program
Hospital Report
IRMS # 7-2501-1015-02/21667**

PLEASE COMPLETE THIS FORM

At risk infants are tracked by the Perinatal Hep B Prevention Program at the Ohio Department of Health (ODH). This form provides the means for us to initiate tracking of an infant born to an HBsAg positive mom. It also triggers replacement of your HBIG used on infants of positive mothers as well as infants of mothers whose Hep B status is not known

Hospital Selected for Delivery:

Phone: _____

Date of Report: _____

Hospital Liaison:

Phone: _____

Mother's Hepatitis B test results:

HBsAg: _____ Date: _____

HBeAg: _____ Date: _____

OB Provider: _____

EDD: _____

Mother's Date of Birth: _____

Race: Asian/Pacific Islander American Indian/Alaskan Native
 Hispanic White
 Black Other:
 Other Locating Address (Work, Emergency Locating, etc.): _____

Mother's Name and Address: _____

Phone: _____

Phone: _____

Infant's Data:

Infant's Name: _____ Sex: F M Delivery Date: _____
 Time: _____
 Infant Weight: _____

Prophylaxis:

HBIG Date: ____/____/____ Time: _____

Hepatitis B Vaccine Date: ____/____/____ Time: _____

Infant died/miscarriage
 Refused for Religious/Philosophical
 Contraindicated (state reason): _____

Give Pediatric Provider assigned (when known):

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

**PLEASE COMPLETE AND FAX
THIS REPORT TO: 614-728-
4279 WITHIN 48 HOURS OF
BIRTH.**

**ATTN:
Perinatal Hepatitis B Nurse
Consultant
Immunization Program
Bureau of Infect. Disease
Control
Ohio Department of Health**

*This report is to obtain replacement of the state supplied HBIG and to initiate tracking of infants to Hep B vaccine series completion. Rev. 5/08