Hospital Hepatitis B Reporting Form

San Bernardino County Department of Public Health Immunizations Program

Perinatal Hepatitis B Prevention Program
451 E. Vanderbilt Way, Ste. 400
San Bernardino, Ca 92408

Phone #: 1-800-722-4794
Fax #: 909-381-8471

Infant's Name _____ **Infant's DOB** _____

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	Unknown

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

Form Completed By: _____ _____

Please fax to (909) 381-8471
If you have any questions please call PHPP at 1-800-722-4794