

HOSPITAL REPORT

FOR FOLLOW-UP OF INFANT(S) BORN TO HBsAg+ MOTHERS OR UNKNOWN MOTHERS

✦ Please fax this report, mother's hepatitis B surface antigen (HBsAg) laboratory report & an admission face sheet to (213) 351-2781 within **24 hours of birth**. Please call (213) 351-7400 if you have any questions.

MOTHER	Mother's Last Name		First Name		Middle Name			
	Medical Record #		DOB		Ethnicity/Race			
	Address: Number, Street			Apt/Unit Number		Mother's Preferred Language		
	City/Town			State		Zip Code		
	Phone # Home		Work			Cell		
	Insurance: (<input checked="" type="checkbox"/> one) <input type="checkbox"/> No Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Private <input type="checkbox"/> Unknown							
INFANT	Type of Test		Test Date		Positive	Pending	Not Done	Negative
	HBsAg (Hepatitis B surface antigen)							
	HBeAg (Hepatitis B e antigen)							
	Obstetrician's Name			Phone #		Fax #		
	Infant's Name	Medical Record #	Sex		Date of Birth	Time	Birth Weight	
	GIVE HEPATITIS B IMMUNOGLOBULIN (HBIG) & HEPATITIS B VACCINE TO INFANT WITHIN 12 HOURS OF BIRTH							
IMMUNOPROPHYLAXIS	Immunoprophylaxis		Date		Time		Vaccine Status Information	
	HBIG 0.5ml		_____		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM		<input type="checkbox"/> Not Given (specify): _____	
	Hep B Vaccine #1		_____		_____ <input type="checkbox"/> AM <input type="checkbox"/> PM		Please check vaccine given: <input type="checkbox"/> Engerix-B (GSK) 0.5ml (10mcg) <input type="checkbox"/> Recombivax-HB (Merck) 0.5ml (5mcg) <input type="checkbox"/> Not Given (specify) _____	
	Name of Pediatrician to Care For Infant After Discharge				Phone #		Fax #	
	Name of Reporting/Delivery Hospital <u>and</u> Address						Phone #	
	Person Reporting (Please Print)				Signature		Date Form Completed	

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(Revised 11/21/12)