

Please complete the information that applies and FAX to: Kelli Smith RN, BSN Perinatal Hepatitis B Coordinator
Questions: Please call: 1-800-831-6293 ext. 7 Fax: 1-800-831-6292

<p>For Women known to be HBsAg Positive</p> <p><input type="checkbox"/> Administer hepatitis B immune globulin (HBIG) and Hepatitis B vaccine within 12 hours of birth.</p> <p><input type="checkbox"/> If your hospital is having difficulty obtaining HBIG please call IDPH at 1-800-831-6293.</p>	<p>For Women whose HBsAg status is Unknown</p> <p><input type="checkbox"/> Perform stat HBsAg screening for all women admitted for delivery whose status is unknown.</p> <p><input type="checkbox"/> While test results are pending, administer hepatitis B vaccine within 12 hours of birth. If the mother is later found to be positive, her infant should receive the additional protection of HBIFG as soon as possible and before the infant is discharged, HBIG must be given within 7 days of birth.</p>
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Name of Hospital: _____

Date Sent: _____

City of Hospital: _____

Mothers Hospital Record #: _____

Note: Only report if mother is **HBsAg Positive**.

Mothers Information	HBsAg(+) Test Date (if done in hospital)*
First Name	Last Name
Date of Birth:	Phone:
Address:	EDC:
City/Zip:	Alternate Phone (i.e. relative):
Physician's Name:	Clinic Name:
Race: <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Black/ African American <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Is the client foreign born <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, country of origin: _____ Is the client English speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what language? _____

*Please send a copy of the labs with this form.

Infant's Information	Hospital Record #:
First Name	Last Name
Date of Birth:	Birth weight: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of HBIG	Date of HBV Vaccine:
HBIG given within 12 Hours of Birth <input type="checkbox"/> Yes <input type="checkbox"/> No	Child entered into IRIS <input type="checkbox"/> Yes <input type="checkbox"/> No
IMPORTANT	
Clinic where baby will receive next dose of vaccine _____	
Infant's Physician Name and Phone: _____	