HOSPITAL REPORT FOR PERINATAL HEPATITIS B

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58464 (Revised 03-2018)

Please complete the information that applies and **FAX** to:**701.328.0355 (Confidential Fax Number)**
If questions, call: 701.328.2335 or 800.472.2180

For Women Known to be HBsAg Positive:	**For Women Whose HBsAg Status is Unknown:**
☐ Administer hepatitis B immune globulin (HBIG) and hepatitis B vaccine within 12 hours of birth to all infants born to hepatitis B positive mothers. If infant doesn't receive HBIG within 12 hours, it can be administered up to 7 days after birth.	☐ Perform a stat HBsAg screening test for all women admitted for delivery whose hepatitis status is unknown. ☐ While test results are pending, the infant should receive 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 HBIG as soon as possible and within 7 days of birth.

Note: Only Report if Mother is HBsAg-positive

Name of Hospital:	City of Hospital:	
Date Sent:		
MOTHER'S INFORMATION		
Mother's Hospital Record Number:	Mother's insurance status(i.e. private, Medicaid, uninsured)	
HBsAg(+) Test Date:		
Last Name:	First Name:	
Address:	City/State:	
Zip Code:	Telephone Number:	Alternate Telephone No. (i.e., relative):
Date of Birth:	Mother's Country of Origin:	Mother's Preferred Language:
Physician's Name:	Clinic Name:	
Race: ☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	

INFANT'S INFORMATION			
Infant's Hospital Record Number:	Insurance status(i.e. private, Medicaid, uninsured)		
Infant's Last Name:	Infant's First Name (if known):		
Infant's ***Date and Time*** of Birth:	Infant's Birth Weight:		
Date Hepatitis B Vaccine given:	***Time*** Hepatitis B Vaccine given:	***Date*** of HBIG Given:	***Time*** HBIG Given:
Infant's Sex (please circle): M F			
IMPORTANT Clinic Where Infant Will Receive HBV2:			
Name of Infant's Pediatrician or PCP (include telephone number if known):			

Race: ☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	

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