

Perinatal Hepatitis B Prevention Program Hospital Report

IRMS#

Hospital Selected for Delivery _____ _____ _____ _____ _____	Please Complete This Form At risk infants are tracked by the Perinatal Hepatitis B Prevention Program at the Ohio Department of Health (ODH). This form provides the means for ODH to track an infant born to an HBsAg positive mother to ensure vaccine series completion. It also triggers replacement of HBIG used on infants of positive mothers as well as infants of mothers whose Hepatitis B status is not known at the time of delivery.
Phone	Date of Report
Hospital Liaison	Phone

Mother Data

Mother's Hepatitis B Test Results			
Mother's Name		Address	
City		State	Zip
Phone		Mother's Insurance <input type="checkbox"/> Private <input type="checkbox"/> Public <input type="checkbox"/> Uninsured	
HBsAg	Date	HBeAg	Date
OB Provider			EDD
Mother's Date of Birth	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Race <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian American <input type="checkbox"/> Indian/Alaskan Native <input type="checkbox"/> Hawaiian Native or Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	

Infant Data

Infant Name		Infant's Insurance <input type="checkbox"/> Private <input type="checkbox"/> Public <input type="checkbox"/> Uninsured	
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Delivery Date	Time	Infant Weight

Prophylaxis

HBIG Date	Time	Hepatitis B Vaccine Date	Time
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Reason for Vaccine Refusal

Infant died/miscarriage Refused for religious/philosophical reasons Contraindicated (State Reason) _____

Pediatric provider upon discharge (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 Coordinator
Bureau of Infectious Diseases
Ohio Department of Health