



HOSPITAL REPORT FOR PERINATAL HEPATITIS B

NORTH DAKOTA DEPARTMENT OF HEALTH

SFN 58464 (Revised 09-2007)

Please complete the information that applies and **FAX to: 701.328.0355 (Confidential Fax Number)**

If questions, call: 701.328.3324 or 800.472.2180

<u>For Women Known to be HBsAg Positive:</u>		<u>For Women Whose HBsAg Status is Unknown:</u>	
<input type="checkbox"/> 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.		<input type="checkbox"/> Perform a stat HBsAg screening test for all women admitted for delivery whose hepatitis status is unknown.	
<input type="checkbox"/> The North Dakota Department of Health supplies HBIG at no charge to birthing hospitals for infants born to HBsAg-positive mothers. Contact 701.328.3386 for more information or to order HBIG.		<input type="checkbox"/> 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:			
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: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
INFANTS'S INFORMATION			
Infant's Hospital Record Number:			
Infant's Last Name:		Infant's First Name (if known):	
Infant's Date of Birth:		Infant's Birth Weight:	
Infant's Sex (please circle): M F		Infant's Date of HBIG Given:	
Infant's Date of Hepatitis B Vaccine Dose 1:			
IMPORTANT			
Clinic Where Infant Will Receive HBV2:			
Name of Infant's Physician (include telephone number if known):			

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