Virginia Perinatal Hepatitis B Prevention Program Infant Information Form

This form is intended for hospitals to report infants born to a birthing parent with either a **known** or **unknown** hepatitis B infection at the time of delivery.

Fax completed form to : 804-864-7259

Perinatal Case ID: _____

Hospital Information

Name of Hospital: _____ Date Completed: _____

Person completing form: _____ Phone Number: _____

Birthing Parent's Information

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____ Phone Number: _____

Provider's Name: _____

Clinic Name: _____ Clinic Phone Number: _____

Hepatitis B Status at Time of Delivery: ☐ Positive ☐ Negative ☐ Unknown Hepatitis B Test Date: _____

Infant's Information

Last Name: _____ First Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Time of Birth: _____ Birth Weight: _____

Date of HBV1: _____ Hours given after birth: _____

Date of HBIG: _____ Hours given after birth: _____

If preterm*, date of 2nd dose of HBV: _____

**Infants <2,000 grams have a decreased immune response to hepatitis B vaccine if given before 1 month of age. Those born to hepatitis B positive mothers must be given HBIG and vaccine within 12 hours of birth and a 2nd dose of hepatitis B vaccine at 1 month of age.*

Infant's Insurance: ☐ Private (includes CHIP) ☐ Public (Medicaid) ☐ Uninsured ☐ Unknown

Vaccine HBIG Replacement

If non-VFC, would you like a replacement for the HBIG and HBV administered to this infant? ☐ Yes ☐ No

If VFC**, would you like a replacement for the HBIG administered for this infant? ☐ Yes ☐ No

***The Virginia Perinatal Hepatitis B Prevention Program cannot replace hepatitis B vaccine for VFC doses administered.*

Infant Provider's Information

Provider Name/Clinic Name: _____

Provider Address: _____

Provider City/State: _____ Provider Zip Code: _____ Provider Phone Number: _____

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