STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Office of Epidemiology and Prevention Services
Division of Immunization Services

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Perinatal Hepatitis B Prevention: Initial Report & Delivery Form

Date of Report:	County:
Mother's Name:	Phone:
Mother's Address:	Mother's Date of Birth:
City, State:	Name/Phone Number of Guardian at Discharge:
Zip Code:	**Insurance: __ Private __ Public (Medicaid) __ Unknown __ CHIP**
Mother's Race: White__ African American__ Asian/Pacific Islander__ Hispanic__ American Indian/Alaskan__ Other__	Mother's Birth County: EDD:

Mother's Hepatitis B Surface Antigen Test Results
Date:_____ HBsAG Positive: Yes___ No___
Name of Conducting Lab:_____
Was testing completed/repeated at time of delivery: Yes___ No___

Please fax a copy of the original lab results with this form

OB Provider:		Phone:
Date of Birth:	Time of Birth:	Sex: Male___ Female___
Infant's Name:		Infant's Birth Weight:
Delivery Hospital:		Phone:

Prophylaxis
HBIG Given: Yes___ No___ Date Given:_____ Time:_____
Hepatitis B Given: Yes___ No___ Date Given:_____ Time:_____
If no, please state reason: _____

HBIG and Hepatitis B #1 should be given within 12 hours of birth

Pediatrician:	Phone:

PLEASE COMPLETE AND FAX THIS FORM TO:
(304) 558-6335
ATTN: Perinatal Hepatitis B Prevention Coordinator
Division of Immunization Services

This form provides the means for us to initiate the tracking of an infant born to an HBsAg positive mother through the completion of the Hepatitis B series and post vaccination serological testing. Local Health Department, please fax a copy of this form to the birthing facility's infection control nurse and/or obstetrics floor to be completed.

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