



Alaska Perinatal Hepatitis B Prevention Program
 3601 C Street, Suite 540
 Anchorage, AK 99503
 Telephone: (907) 269-8000
 Fax: (907) 562-7802



CONFIDENTIAL: Hospital Report for Perinatal Hepatitis B

Please **PRINT** and complete the information that applies and **FAX to: (907) 562-7802 (Confidential Fax Number)**. If you have questions, call DHSS/DPH at (907) 269-8000.

<p><u>For Women Known to be HBsAg Positive:</u></p> <p><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.</p>	<p><u>For Women Whose HBsAg Status is Unknown:</u></p> <p><input type="checkbox"/> Perform a stat HBsAg screening test for all women admitted for delivery whose hepatitis status is unknown.</p> <p><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</p>
NOTE: ONLY Report if Mother is HBsAg positive!	
Name of Hospital:	City of Hospital:
Date Sent:	Does Mother have Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Insurance:
Mother's Information	
Mother's Hospital Record Number:	
HBsAg (+) Test Date:	
Name:	Date of Birth:
Address:	City/State/Zip Code:
Telephone Number:	Alternate Telephone Number (i.e., relative):
Mother's Country of Origin:	Mother's Preferred Language:
Physician's Name:	Clinic Name:
Race:	Ethnicity:
<input type="checkbox"/> Asian <input type="checkbox"/> American <input type="checkbox"/> Black/African American <input type="checkbox"/> Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Infant's Information	
Infant's Hospital Record Number:	
Infant's Name:	Infant's Date of Birth: Time of birth:
Infant's Birth Weight:	Infant's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Infant's Date of HBIG given: Time HBIG given:	Infant's Date of Hepatitis B Vaccine Dose 1: **IMPORTANT** Clinic where Infant will receive HBV2:
Name of Infant's Physician:	Telephone Number: () -