Perinatal Hepatitis B Prevention Program
Provider/Hospital Report of HBsAg-Positive Mother

Texas Dept of State Health Services
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Reported by: ☐ Prenatal Health Care Provider ☐ Delivery Hospital

Please be sure that all appropriate areas of the form are completed

	Name	Contact Number	Address
Reporter (Person Completing Form)		Office Number: Fax Number:	
Mother's OB/GYN		Office Number: Fax Number:	
Pediatric Provider (**After Discharge**)		Office Number: Fax Number:	
Mother		Home Phone: Work Phone:	
Infant's Full Given Name		Home Phone:	
Planned Delivery Hospital		Office Number: Fax Number:	

MOTHER'S INFORMATION:

DOB: ____/____/____

Medicaid # if applicable: ______________

Race/Ethnicity: ____________________

Reproductive History: Gravida: _____ Para: _____

Preferred language:
☐ English ☐ Chinese
☐ Korean ☐ Spanish
☐ Vietnamese ☐ Other ______________

Estimated Due Date (EDD): ____/____/____

Is mother being monitored for Hepatitis B by a Physician Specialist? ☐ Yes ☐ No

Is mother a chronic carrier of Hep B? ☐ Yes ☐ No

If mother is receiving treatment medication for chronic Hep B indicate start date (if known):
____/____/____

Does Mother have other infections / conditions?
☐ Hepatitis C ☐ HIV ☐ Syphilis

Date Of Form Completion: _____

MOTHER'S SEROLOGY RESULTS:

Date(s) of Result: ____/____/____

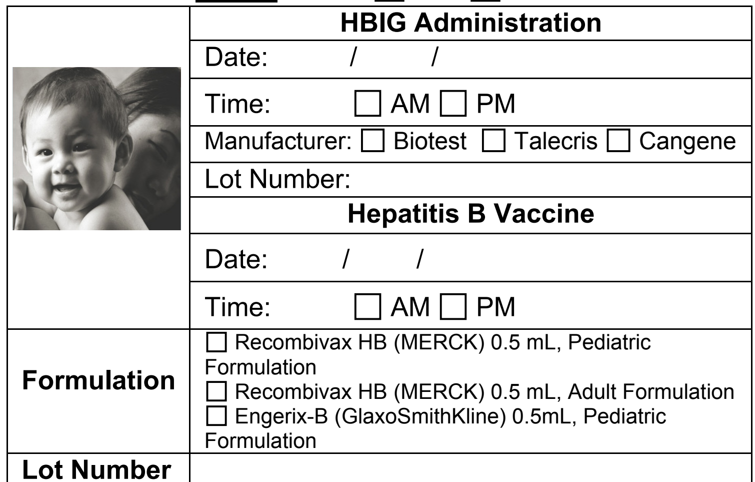
HBsAg	Result	☐Reactive	☐Non-reactive
Anti-HBs	Result	☐Reactive	☐Non-reactive
Anti-HBc	Result	☐Reactive	☐Non-reactive
Anti-HBC Igm	Result	☐Reactive	☐Non-reactive
HBeAg	Result	☐Reactive	☐Non-reactive

Please send a copy of mom's labs when submitting report

INFANT'S INFORMATION:

DOB: ____/____/____ Weight:_____ Gender: M F

Time of Birth: _____ ☐ AM ☐ PM



	HBIG Administration
	Date: / /
	Time: ☐ AM ☐ PM
	Manufacturer: ☐ Biotest ☐ Talecris ☐ Cangene
	Lot Number:
	Hepatitis B Vaccine
	Date: / /
	Time: ☐ AM ☐ PM
Formulation	☐ Recombivax HB (MERCK) 0.5 mL, Pediatric Formulation ☐ Recombivax HB (MERCK) 0.5 mL, Adult Formulation ☐ Engerix-B (GlaxoSmithKline) 0.5mL, Pediatric Formulation
Lot Number	