



Perinatal Hepatitis B Prevention Program
 Infectious Disease Intervention and Control Branch
 Texas Department of State Health Services
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 Austin, Texas 78714-9347
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Prenatal Health Care Provider/Hospital Report of HBsAg-positive Mother

Reported by: Prenatal Health Care Provider Delivery Hospital

IDENTIFICATION:

	Name	Phone Number	Address
Reporter			
Mother's OB/GYN			
Pediatric Health Care Provider			
Mother			
Infant			
Planned Delivery Hospital			

MOTHER'S INFORMATION:

DOB: ____ / ____ / ____

Reproductive History:

Gravida: ____ Para: ____

Preferred language:

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other _____ |

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

MOTHER'S SEROLOGY RESULTS:

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

- | | | | |
|---------------------------------------|---------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> HBsAg | Result: | <input type="checkbox"/> Reactive | <input type="checkbox"/> Non Reactive |
| <input type="checkbox"/> anti-HBs | Result: | <input type="checkbox"/> Reactive | <input type="checkbox"/> Non Reactive |
| <input type="checkbox"/> anti-HBc | Result: | <input type="checkbox"/> Reactive | <input type="checkbox"/> Non Reactive |
| <input type="checkbox"/> anti-HBc IgM | Result: | <input type="checkbox"/> Reactive | <input type="checkbox"/> Non Reactive |
| <input type="checkbox"/> HBeAg | Result: | <input type="checkbox"/> Reactive | <input type="checkbox"/> Non Reactive |

INFANT'S INFORMATION:

DOB: ____ / ____ / ____ Weight: ____

Time of birth: _____ AM PM

	HBIG Administration
	Date: ____ / ____ / ____
	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
	Manufacturer: _____
	Hepatitis B Vaccine
	Lot Number: _____
	Date: ____ / ____ / ____
	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Formulation	<input type="checkbox"/> Recombivax HB (MERCK) 0.5mL, Pediatric Formulation <input type="checkbox"/> Recombivax HB (MERCK) 0.5mL, Adult Formulation <input type="checkbox"/> Engerix-B (GlaxoSmithKline) 0.5mL, Pediatric Formulation
Lot Number	_____