

HOSPITAL REPORT

FOR FOLLOW-UP OF INFANT(S) BORN TO HBsAg+ MOTHERS OR UNKNOWN MOTHERS

✦ Please fax this report, mother's hepatitis B surface antigen (HBsAg) laboratory report & an admission face sheet to (213) 351-2781 within **24 hours of birth**. Please call (213) 351-7400 if you have any questions.

MOTHER	Mother's Last Name		First Name		Middle Name		
	Medical Record Number		DOB		Ethnicity/Race		
	Address: Number, Street		Street Apt/Unit Number		Mother's Preferred Language		
	City/ Town		State		Zip Code		
	Phone Numbers Home		Work		Cell		
	Insurance: (<input checked="" type="checkbox"/> one) <input type="checkbox"/> No Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Private <input type="checkbox"/> Unknown						
INFANT	Type of Test		Test Date		Positive		
	HBsAg (Hepatitis B surface antigen)				<input type="checkbox"/>		
	HBeAg (Hepatitis B e antigen)				<input type="checkbox"/>		
	Obstetrician's Name		Phone #		Fax #		
	Infant's Name		Medical Record #	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Time	Birth Weight
	GIVE HEPATITIS B IMMUNOGLOBULIN (HBIG) & HEPATITIS B VACCINE TO INFANT WITHIN 12 HOURS OF BIRTH						
IMMUNOPROPHYLAXIS	Immunoprophylaxis		Date		Time		
	HBIG 0.5ml		_____		<input type="checkbox"/> AM <input type="checkbox"/> PM _____		
	Hep B Vaccine #1		_____		<input type="checkbox"/> AM <input type="checkbox"/> PM _____		
					Please check vaccine given: <input type="checkbox"/> Engerix-B (GSK) 0.5ml (10mcg) <input type="checkbox"/> Recombivax-HB (Merck) <input type="checkbox"/> 0.5ml (5mcg) <input type="checkbox"/> Not Given (specify) _____		
	Name of Pediatrician to Care For Infant After Discharge			Phone #		Fax #	
	Reporting/Delivery Hospital		Please Print Name of Reporting Person			Signature	
Date Form Completed				Phone Number			

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