Perinatal Hepatitis B Prevention Unit, Bureau of Immunization
New York City Department of Health and Mental Hygiene
42-09 28th Street, CN-21, 5th Floor ÅQueens, NY 11101-4132
TEL: 347-396-2403 Å FAX: 347-396-2558 or 347-396-2559

N.Y. State Public Health Law 2500-e mandates prenatal screening of all pregnant women for hepatitis B surface antigen (HBsAg). Providers attending pregnant women testing HBsAg positive are required to report information under (1) and (3). Providers attending infants born to HBsAg positive mothers are required to report information under (1), (2) and (3). Please mail to above address or fax to one of the fax numbers.

1. MOTHER INFORMATION: Prenatal Care: ☐ Yes ☐ No | Medical Record #:

Name: *Last* *First* *Middle* | Date of Birth: __ __ / __ __ / __ __ __ __

Address: *No. and Street* *Apt.* *City/Borough* *Zip Code*

Telephone:
Home (__ __ __) __ __ __ – __ __ __ __ *Work* (__ __ __) __ __ __ – __ __ __ __ *Cell* (__ __ __) __ __ __ – __ __ __ __

Expected Date of Delivery: __ __ / __ __ / __ __ | Expected Birth Hospital:

Test	Date(s)	Result *(Pos/Neg)*	Ordering Facility: *Name and Address*	Ordering Physician: *Name (First and Last) and Phone*
HBsAg				

2. INFANT INFORMATION: Infant Chart #: | Maternal Delivery Chart #:

Name: *Last* *First* *Middle* | Date of Birth: __ __ / __ __ / __ __

Birthing Facility *(Name)*: | Time: ☐ AM ☐ PM __ __ : __ __

Birth Weight: _____ lbs _____ oz *OR* _____ grams | Gestational Age: _____ weeks

Recommended Schedule for Infants Born to HBsAg (+) Mothers: *Administer HBIG and the 1st dose HepB within 12 hours of birth, and the 2nd dose HepB at 1 month (use only monovalent HepB for these doses.) Complete the series with any HepB vaccine (monovalent or combination) following the recommended schedule with the final dose given no sooner than 24 wks of age.*

Vaccination Information		Date	Facility: *Name and Address*	Physician: *Phone and Name (First and Last)*
HBIG	Time ☐ AM ☐ PM ____ : ____			
HEP B-1	Time ☐ AM ☐ PM ____ : ____			
HEP B-2	Vaccine Brand Name			
HEP B-3	Vaccine Brand Name			
HEP B-4	Vaccine Brand Name			

Recommended Testing Protocol for Infants Born to HBsAg (+) Mothers: *Test for both Anti-HBs (quantitative) and HBsAg at 9 months of age, without exception. Quantitative Anti-HBs values > 10mIU/ml are consistent with immunity: please indicate value in space provided.*

HBsAg Date: __ __ / __ __ / __ __ ☐ Positive ☐ Negative

Anti-HBs Date: __ __ / __ __ / __ __ ☐ Positive ☐ Negative Quantitive Value: _____ mIU/ml

3. REPORTER INFORMATION:

Name/Title of Person Completing Form:

☐ Infection Control Dept. ☐ Newborn Nursery ☐ Pediatrician Office ☐ OB/GYN Office ☐ Other:

Provider/Facility: *Name, Address*

Telephone: (__ __ __) __ __ __ – __ __ __ __

Report Date: __ __ / __ __ / __ __ __ __