



# HOSPITAL REPORT OF PERINATAL HEPATITIS B

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 DISEASE CONTROL AND FORENSIC PATHOLOGY  
 SFN 58464 (1-2026)

Please complete the information that applies and **FAX to 701.328.0355 (Confidential)**

**If questions, call 701.328.2378 or 800.472.2180 (ND Only)**

<p><b><u>For Women Known to be HBsAg Positive</u></b></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><b><u>For Women Whose HBsAg Status is Unknown</u></b></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>
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**NOTE: ONLY REPORT IF MOTHER IS HBsAg-Positive**

Name of Hospital	City of Hospital
Date Sent	

**MOTHER'S INFORMATION**

Mother's Hospital Record Number	Mother's insurance status(i.e. private, Medicaid, uninsured)	
HBsAg(+) Test Date		
Last Name	First Name	
Address	City/State	
Zip Code	Telephone Number	Alternate Telephone No. (i.e., relative)
Date of Birth	Mother's Country of Origin	Mother's Preferred Language
Physician's Name		Clinic Name
Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Asian		Ethnicity <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	Insurance status(i.e. private, Medicaid, uninsured)		
Infant's Last Name	Infant's First Name (if known)		
Infant's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Infant's Birth Weight	Infant's <b>Date and Time</b> of Birth	
<b>Date</b> Hepatitis B Vaccine given	<b>Time</b> Hepatitis B Vaccine given	<b>Date</b> HBIG Given	<b>Time</b> HBIG Given
<b>**IMPORTANT**</b> Clinic Where Infant Will Receive HBV2			
Name of Infant's Pediatrician or PCP (include telephone number if known)			
Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Asian		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	