

PERINATAL HEPATITIS B SURVEILLANCE FORM

SECTION I: PRENATAL CARE

Part A: Mother Information

1. Last Name _____ 2. First Name _____
3. Address _____ Address #2 _____
4. City _____ 5. Zip _____ 6. Parish _____
7. Phone _____ Alternate Phone _____
8. Age _____ 9. Date of Birth ____/____/____
mo day yr 10. Primary language _____
11. Race (check): White Black Asian/Pacific Islander Other _____ 12. Ethnicity: Hispanic Non-Hispanic

Part B: Medical Information (Mother)

1. Prenatal care received? Yes No 2. Health Insurance Status: Medicaid Private Insurance Other _____
3. Name of prenatal care provider/clinic name _____ 4. Clinic Phone # _____
Clinic Fax # _____
5. Date hepatitis B labs collected ____/____/____
mo day yr
HBsAg test result (during this pregnancy) Pos Neg
PLEASE ATTACH A COPY OF THE PATIENT'S HEPATITIS B LAB RESULTS
6. Expected delivery date ____/____/____
mo day yr
7. Expected hospital of delivery _____

SECTION II: DELIVERY HOSPITAL CARE

Part A: Mother

1. Pregnancy outcome live birth stillborn miscarriage pregnancy terminated
2. Hospital of delivery _____

Part B: Infant

1. Last Name _____ 2. First Name _____
3. Date of Birth ____/____/____ 4. Birth time ____:____ am/pm 5. Birth weight _____
mo day yr hr mn
6. Sex Female Male 7. Health Insurance Status at Birth: Medicaid Private Insurance Other _____
8. HBIG date ____/____/____ HBIG time ____:____ am/pm
mo day yr hr mn
9. 1st dose HepB vaccine date ____/____/____ 1st dose HepB vaccine time ____:____ am/pm
mo day yr hr mn
10. Name of pediatrician/clinic name _____ 11. Clinic Phone # _____
Clinic Fax # _____

Please fax or mail form to: Louisiana Department of Health and Hospitals
Office of Public Health-Immunization Program
Attn: Hepatitis Program Manager
(504) 838-5300
(504) 838-5206 fax

