



## Vermont Perinatal Hepatitis B Prevention Program FAX TRANSMITTAL

To: **Vicki Swenor RN**, *Perinatal Hepatitis B Prevention Program Coordinator*

Fax: (802) 786-5984

From Contact: \_\_\_\_\_

Hospital: \_\_\_\_\_

Fax: \_\_\_\_\_

Re: **Infant born to mother who is HBsAg positive**

<b>Mother name:</b>	
Mother date of birth:	
Mother address: (street, city, county)	
Obstetric care provider: (name, phone)	
----- <input type="checkbox"/> ER walk in, no prenatal care	
<b>Infant name:</b>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Primary Care Provider: (name & practice)	
Infant date & time of birth _____ @ _____	
HBIG administered: date _____ & time _____ <input type="checkbox"/> HBIG not administered in hospital (reason, if known)	
Hepatitis B vaccine administered: date _____ & time _____ <input type="checkbox"/> Hepatitis B vaccine not administered in hospital (reason if known)	
<input type="checkbox"/> <b>FAX copy of <u>original confirmatory HBsAg test result</u> with this page.</b> <b>Thank you.</b>	