VERMONT
DEPARTMENT OF HEALTH

State of Vermont Department of Health 280 State Drive, Waterbury, Vermont 05671

Vermont Perinatal Hepatitis B Prevention Program

CONFIDENTIAL FAX TRANSMITTAL

To: Perinatal Hepatitis B Prevention Program
Coordinators Fax: (802) 951-4061
From Contact: _____
Hospital: _____
Fax: _____

Re: Infant born to mother who is HBsAg positive

Mother Name: D.O.B.:
Mother Insurance Type:
Mother address: (street, city, county)
Obstetric care provider: (name, phone)
☐ ER walk in, no prenatal care
Infant Name: Male ☐ Female ☐ Infant MRN:
Infant Insurance Type:
Primary Care Provider: (name & practice)
Infant DOB:_____ Time of Birth:_____ Wgt:_____
☐ HBIG administered Date:_____ Time:_____ ☐ HBIG not administered in hospital (reason, if known)
☐ Hepatitis B vaccine administered Date:_____ Time:_____ ☐ Hepatitis B vaccine not administered in hospital (reason if known)
☐ FAX copy of original confirmatory HBsAg test result with this page