

Vermont Perinatal Hepatitis B Prevention Program

CONFIDENTIAL FAX TRANSMITTAL

To: **Veronica Fialkowski**, Perinatal Hepatitis B Prevention Program Coordinator

Fax: (802) 951-4061

From Contact: _____

Hospital: _____

Fax: _____

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

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