VERMONT

State of Vermont Department of Health 108 Cherry Street, PO Box 70, Burlington, VT 05402

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	**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	**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	**FAX copy of <u>original confirmatory HBsAg test result</u> with this page**