Montana Perinatal Hepatitis B Prevention Program

Primary Report
for HBsAg Positive Pregnant Women

Case Demographic

_____/_____ ___
Last Name First Name MI

____/____/____ _____
Birth date Country of Birth

Other Information

Hepatitis B: ☐ Acute ☐ Chronic

Estimated Date of Delivery (EDD) : ____/____/____

Healthcare Provider (mother): _____

Healthcare Provider (infant): _____

Anticipated Birth Facility: _____

Insurance Status: □ Private □ Public □ Uninsured □ Unknown

Complete all the above information and fax to Program Coordinator at 444-2920

____/____/____ Date HBIG was received at the birth facility

____/____/____ Date Birth Facility Report Form was delivered to birth facility

Additional Forms to be Completed (□ check and date when completed- for county use only)

□ __/__/____Montana DPHHS Communicable Disease Case Report

□ __/__/____ Perinatal Hepatitis B Prevention Program Primary Report

□ __/__/____ Contact Investigation Line List

□ __/__/____Hospital/Birth Facility Report

□ __/__/____Infant Report

Montana Immunization Program
For Questions please call 444-1805 or 444-5580
Fax (406) 444-2920
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