Montana Perinatal Hepatitis B Prevention Program

Hospital/Birth Facility Report Form

To Report Newborn Infant of a Hepatitis B Surface Antigen (HBsAg) Positive Mother

Administrative Rules of Montana 37.114.540

Please fax this completed document within 7 days of infant delivery to Local Health Department:

Local Health Department (contact information)

Case Information:

_____ Mother's Name

____/____/____ Date of Birth

____/____/____ Estimated Date of Delivery

Medication Administered

- **Hepatitis B Immune Globulin (HBIG): to be given 0.5 ml, IM, within 12 hours of birth**
- **Hepatitis B Vaccine: to be given 0.5 ml, IM, concurrently with HBIG, but in a different site/extremity**

_____ Infant Name

____/____/____ Date of Birth

_____am/pm Time of Birth

Male/ Female Sex (circle one)

_____grams _____lbs Birth Weight

HBIG given: _____ Dose, Route, Site _____am/pm ____/____/____

Hepatitis B Vaccine given: _____ Dose, Route, Site _____am/pm ____/____/____

_____ Nurse signature

_____ Birth Facility/Hospital

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