DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

MONTANA PERINATAL HEPATITIS B PREVENTION PROGRAM
BIRTH FACILITY REPORT FORM

Must Be Completed and Sent Via Confidential Fax or Other Secure Method to The Local Health Department Within 7 Days Of Delivery

To Be Completed By Local Health Department

Local Health Department Information

Local Health Department: _____

Contact Name: _____ **Contact Phone Number:**_____

Contact Email:_____ **Confidential Fax Number:** _____

Mother's Information

Name:_____ **Date of Birth:** _____

Estimated Date of Delivery: _____

To Be Completed By Birth Facility

Infant's Information

Name:_____ **Date of Birth:**_____

Time of Birth:_____ **Birth Weight:**_____ ☐ **Grams** ☐ **lbs/oz**

Gender: ☐ **Male** ☐ **Female**

Birth Facility Name:_____

Birth Facility Contact Name and Number:_____

The following must be administered in separate sites/extremities within 12 hours of birth:

- **Hepatitis B Immune Globulin (HBIG): 0.5mL, IM**
- **Hepatitis B Vaccine: 0.5mL, IM**

HBIG Given: Date_____ **Time**_____

Hepatitis B Vaccine Given: Date _____ **Time**_____

_____ _____

Nurse Signature **Date**

Requirement To Report Newborn Infant of a Hepatitis B Surface Antigen (HBsAg) Positive Mother: Administrative Rules of Montana 37.114.540