



**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		
<ul style="list-style-type: none"> 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	<u>Male/ Female</u>	_____ grams _____ lbs
Time of Birth	Sex (circle one)	Birth Weight
HBIG given: _____	_____ am/pm	_/_/____
Dose, Route, Site		
Hepatitis B Vaccine given: _____	_____ am/pm	_/_/____
Dose, Route, Site		
_____	_____	
Nurse signature	Birth Facility/Hospital	