



**Montana Perinatal Hepatitis B
Prevention Program**

**Primary Report
for HBsAg Positive Pregnant Women**

Case Demographic
<div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> _____ / _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> Last Name First Name MI </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> ____/____/____ _____ </div> <div style="display: flex; justify-content: space-between;"> Birth date Country of Birth </div>
Other Information
<p>Hepatitis B: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic</p> <p>Estimated Date of Delivery (EDD) : ____/____/____</p> <p>Healthcare Provider (mother): _____</p> <p>Healthcare Provider (infant): _____</p> <p>Anticipated Birth Facility: _____</p> <p>Insurance Status: <input type="checkbox"/> Private <input type="checkbox"/> Public <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown</p> <p align="center"><u>Complete all the above information and fax to Program Coordinator at 444-2920</u></p> <p>____/____/____ Date HBIG was received at the birth facility</p> <p>____/____/____ Date Birth Facility Report Form was delivered to birth facility</p>
Additional Forms to be Completed (<input type="checkbox"/> check and date when completed- for county use only)
<p><input type="checkbox"/> ____/____/____ Montana DPHHS Communicable Disease Case Report</p> <p><input type="checkbox"/> ____/____/____ Perinatal Hepatitis B Prevention Program Primary Report</p> <p><input type="checkbox"/> ____/____/____ Contact Investigation Line List</p> <p><input type="checkbox"/> ____/____/____ Hospital/Birth Facility Report</p> <p><input type="checkbox"/> ____/____/____ Infant Report</p>