NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Perinatal Hepatitis B Prevention Program (PHBPP) Report Form

The PHBPP report form, intended for use with every newborn, serves as a hospital checklist and communication tool. For every newborn, whose mother is HBsAg positive or unknown, please fax the completed report form to your Local Health Department PHBPP Coordinator within 24 hours of birth.

Hospital Name _____ **Local Health Department** _____

Mother's Information

Mother's Name: _____
Mother's DOB: _____
Medical Record Number: _____
Guardian if different from Mother: _____
Street Address: _____
City, State, ZIP code: _____
Phone: _____

Newborn's Information

Infant's Name: _____
DOB: _____ ☐ Male ☐ Female
Birth Weight: _____ Grams
Time of Delivery: _____ AM/PM
Medical Record Number: _____
Indicate if infant has been adopted or placed in foster care:
_____

Prenatal Care Provider

Name: _____
(Indicate none if no prenatal care)
Street Address: _____
City, State, ZIP code: _____
Phone: _____

Newborn's Physician/Provider after Discharge

Name: _____
Street Address: _____
City, State, ZIP code: _____
Phone: _____

Maternal Hepatitis B Surface Antigen (HBsAg) Testing and Status *(Check all that apply.)*

A. Maternal HBsAg testing

- ☐ Report of the original HBsAg lab result is in **(1)** the pregnant woman's labor and delivery (L&D) record **AND** **(2)** the infant's hospital record (or have an electronic link to the mother's HBsAg lab result).
- ☐ Repeat blood test for HBsAg was drawn upon admission. (Please indicate reason)
  - ☐ Identified risk factors for acquiring hepatitis B virus (HBV) infection during this pregnancy (e.g., more than one sex partner in the previous 6 months, evaluation or treatment for a sexually transmitted disease, recent or current injection drug use, or HBsAg-positive sex partner), **OR**
  - ☐ Clinical signs and symptoms of hepatitis infection since her previous testing.
- ☐ Mother's HBsAg status is unknown (no lab result available) upon upon admission: Hospital arranged for immediate testing of the mother with results available within 24 hours, or as soon as practical, but not longer than 48 hours.
- ☐ Mother refused HBsAg test / retest. Efforts to obtain test and refusal documented in medical record.

B. **Mother** tested **HBsAg Negative** during this pregnancy (be sure the test date falls in this prenatal period).

- ☐ Recommended universal birth dose of single-antigen hepatitis B vaccine (0.5 mL, intramuscular (IM)) was administered to the newborn (medically stable, ≥ 2,000 gms) within 12 hours of birth, **OR**
- ☐ Recommended universal birth dose was offered but was refused. Refusal documented in medical record.

C. **Mother** tested **HBsAg Positive** during this pregnancy (be sure the test date falls in this prenatal period).

- ☐ Hepatitis B Immune Globulin (HBIG) (0.5 mL, IM) **AND** single-antigen hepatitis B vaccine (0.5 mL, IM) was administered to the newborn at separate injection sites within 12 hours of birth, **OR**
- ☐ Newborn did not receive HBIG and hepatitis B vaccine as recommended. (Please indicate reason)
  - ☐ Valid medical exemption or religious exemption documented in the medical record, **OR**
  - ☐ Parent/legal guardian refused HBIG/hepatitis B vaccine for newborn. Refusal documented in the medical record.
    - ☐ A report of suspected child abuse or maltreatment has been made.

D. **Mother HBsAg Unknown** during this pregnancy.

- ☐ Single-antigen hepatitis B vaccine (0.5 mL, IM) was administered to the newborn within 12 hours of birth, **OR**
- ☐ Parent/legal guardian refused hepatitis B vaccine for newborn. Refusal documented in the medical record.

☐ Newborn discharged before the mother's HBsAg test result is known. (Please indicate follow-up)
- ☐ The mother's and newborn's healthcare providers were notified that the mother's HBsAg test result is pending.
- ☐ If the mother is found to be HBsAg-positive, the mother and the newborn's healthcare provider will be notified that the infant should receive HBIG as soon as possible, but no later than seven days after birth.

Infant Immunization

HEPATITIS B VACCINE	HBIG *(if applicable)*
Date Administered:	Date Administered:
Time Administered: AM/PM	Time Administered: AM/PM
Dose/Route/Site of Administration:	Dose/Route/Site of Administration:
Manufacturer:	Manufacturer:
Manufacture Lot #:	Manufacture Lot #:
Expiration Date:	Expiration Date:

☐ The parents received Hepatitis B Vaccine Information Statement before vaccine administration, **http://www.immunize.org/vis/vis_hepatitis_b.asp**

☐ The date, time, site of administration, and vaccine lot number were documented in the newborn's medical record.

☐ Mother provided *Certificate of Immunization* for the newborn with immunizing agents, date of administration, and date for next dose documented.

Hepatitis B Care Status *(complete if Mother is HBsAg positive or unknown)*

☐ Advised the mother that she may breastfeed her infant.

☐ Post-discharge postpartum care made for the mother, including a medical evaluation for chronic hepatitis B, with an assessment of whether she is a candidate for antiviral treatment, if indicated.

☐ Well-baby care and post-exposure prophylaxis appointments made for the baby (provider aware of the newborn's birth, the date and time of HBIG and hepatitis B vaccine doses administered).

☐ Mother is aware of the importance of: (1) Hepatitis B vaccine series completion to protect her baby; (2) Blood test for her baby (HBsAg and antibody to hepatitis B surface antigen [anti-HBs]) 1–2 months after completion of the 3- or 4-dose hepatitis B vaccine series and no earlier than 9–12 months of age to determine if the baby developed a protective immune response to vaccination or needs additional management; (3) Modes of HBV transmission; (4) Need for testing and vaccination of susceptible household, sexual, and needle-sharing contacts; and (5) Need for follow-up with her medical provider for positive or unknown hepatitis B status.

☐ This completed form was faxed, within 24 hours of birth, to the local health department PHBPP Coordinator.

Name: _____ at fax# _____

Person Completing This Form

Name/ Title: _____

Date: _____ Phone: _____

Local Health Department to Complete

Received by: _____ Date: _____