



State of Vermont Department of Health 108 Cherry Street, PO Box 70, Burlington, VT 05402

Vermont Perinatal Hepatitis B Prevention Program CONFIDENTIAL FAX TRANSMITTAL

To: **Veronica Fialkowski**, Perinatal Hepatitis B Prevention Program Coordinator

Fax: (802) 951-4061

From Contact: _____

Hospital: _____

Fax: _____

Re: **Infant born to mother who is HBsAg positive**

Mother name:	D.O.B.:
Mother Insurance type:	
Mother address: (street, city, county)	
Obstetric care provider: (name, phone)	
<input type="checkbox"/> ER walk in, no prenatal care	
Infant name:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Primary Care Provider: (name & practice)	
Infant Insurance type:	
Infant date & time of birth _____ @ _____ Wgt: _____	
HBIG administered: date _____ & time _____ <input type="checkbox"/> HBIG not administered in hospital (reason, if known)	
Hepatitis B vaccine administered: date _____ & time _____ <input type="checkbox"/> Hepatitis B vaccine not administered in hospital (reason if known)	
<input type="checkbox"/> FAX copy of <u>original confirmatory HBsAg test result</u> with this page. Thank you.	