46339

v1.3 - 10/04/2018

Massachusetts Department of Public Health
Bureau of Infectious Disease Prevention, Response and Services
305 South Street, Room 563, Jamaica Plain, MA 02130
Phone: 617-983-6800 Confidential Fax: 617-983-6220

Received in Surveillance: __ / __ / ____

Hepatitis B Maternal/Infant Birth Reporting Form

Confidential Case Report

Hospital Name:

Completed By:

Date Form Completed: (mm/dd/yyyy) __ / __ / ____ **Phone:** ( ) -

MOTHER'S INFORMATION

Mother: _Last_, _First_ _Middle_

Address: **City** **St** **Zip**

Date of Birth: (mm/dd/yyyy) __ / __ / ____ **Phone Number:** ( ) -

Race:
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African Am.
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Unk
- ☐ Other

Hispanic:
- ☐ Yes
- ☐ No
- ☐ Unk

Type of Insurance:
- ☐ Medicaid
- ☐ Private
- ☐ Medicare
- ☐ Uninsured
- ☐ Unknown

Does Mom speak English?: Yes ☐ No ☐ **If NO, Language:**

DELIVERY INFORMATION

Delivery Date: (mm/dd/yyyy) __ / __ / ____

Prenatal OB Name:

Phone: ( ) -

INFANT'S INFORMATION

Infant: _Last_, _First_ _Middle_

Address: **City** **St** **Zip**

Date of Birth: (mm/dd/yyyy) __ / __ / ____

Sex:
- ☐ Male
- ☐ Female
- ☐ Unk

Race:
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African Am.
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Unk
- ☐ Other

Hispanic:
- ☐ Yes
- ☐ No
- ☐ Unk

Date HBIG Administered: (mm/dd/yyyy) __ / __ / ____

Date 1st Dose HepB Vacc: (mm/dd/yyyy) __ / __ / ____

Birth weight (grams):

Pediatrician Name:

Phone: ( ) -

Make solid marks that fit in the response boxes. Please use black or blue ink. Right way -> AB Wrong way -> A B

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