

**County of Santa Clara
Public Health Department**

Communicable Disease Prevention and Control
Perinatal Hepatitis B Prevention Program
976 Lenzen Avenue, 1st Floor, Suite 1200
San Jose, CA 95126
Tel: (408) 885-4214 Fax: (408) 792-1304



Notification of HBsAg-exposed Infant/Child (age 0 to 2 years)

To: Perinatal Hepatitis B Prevention Program

Date:

From:

Phone #:

Fax:

Use this form when pediatrician doesn't receive the "Hepatitis B Pediatric Flowsheet" from the Perinatal Hepatitis B Prevention Program on an HBsAg-exposed infant/child under age of 2. Please complete and fax this notification to the program after hepatitis B vaccine series and post-vaccine serology are completed.

The recommended hepatitis B vaccine schedule for HBsAg-exposed infants is **accelerated**. The vaccine and post-vaccine serology schedules are as follows:

- HBV # 1 (hepatitis B vaccine) and HBIG (hepatitis B immune globulin) given at birth
- HBV # 2 given at one to two months of age
- HBV # 3 given at six months of age
- **Note:** Vaccine schedule may differ if combination vaccine is used. Please see Hepatitis B Vaccine Schedule Table for more information.
- Check post vaccination serology with HBsAg and anti-HBs testing 1-2 months after completing the vaccine series, but not before 9 months of age
- If the blood test results are HBsAg and antibody (anti-HBs) negative or non-reactive, repeat the hepatitis B vaccine series right away with the same intervals, and then do another blood test 1-2 months after this 2nd HBV series is completed.

Mother's Name _____ DOB _____ MR# _____

Address _____

Phone (H) _____ (W) _____ (C) _____

Mother's current/past prenatal care provider _____ Phone _____

Infant Name _____ **Gender** _____ **DOB** _____ **Time** _____

MR# _____ **Hospital** _____ **HBIG Date** _____ **Time** _____

Hep B Vaccine Dates (1) _____ **Time** _____ (2) _____ (3) _____ (4) _____

Blood Test Result (Please attach a lab report)

Date of Test	HBsAg (Hep B surface antigen) <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE	Anti-HBs / HBsAb (Hep B surface antibody) <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE
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Comment: _____

X _____
Physician's Name (Printed or Stamp) _____ Date _____