County of Santa Clara
Public Health Department
Communicable Disease Prevention and Control
Perinatal Hepatitis B Prevention Program
150 W. Tasman Dr, 1st Floor
San Jose, CA 95134
Tel: (408) 970-2830 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) ☐ POSITIVE ☐ NEGATIVE	**Anti-HBs / HBsAb** (Hep B surface antibody) ☐ POSITIVE ☐ NEGATIVE

Comment: _____

X_____
Physician's Name (Printed or Stamp) Date