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

To: Perinatal Hepatitis B Prevention Program

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)

<table>
<thead>
<tr>
<th>Date of Test</th>
<th>HBsAg (Hep B surface antigen)</th>
<th>Anti-HBs / HBsAb (Hep B surface antibody)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ POSITIVE □ NEGATIVE</td>
<td>□ POSITIVE □ NEGATIVE</td>
</tr>
</tbody>
</table>

Comment: _________________________________________________________________________________

X

Physician’s Name (Printed or Stamp)           Date

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