County of Santa Clara
Public Health Department
Disease Prevention & Control
Perinatal Hepatitis B Prevention Program
976 Lenzen Avenue, Suite 1203
San Jose, CA 95126
Tel (408) 885-4214 Fax (408) 792-1304 www.sccphd.org/perinatalhepb

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. (Available at https://www.sccgov.org/sites/sccphd/en-us/HealthProviders/HepB/Pages/InfantCare.aspx)
- 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.

* *Hepatitis B infection is one of the diseases listed in The California Code of Regulations that health care providers are required to report to the local public health department. Mandated public health reporting is exempted from HIPAA restrictions; patient consent is not required.*

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