

Louisiana Department of Health and Hospitals
Office of Public Health
PERINATAL HEPATITIS B SURVEILLANCE FORM

SECTION I: PRENATAL CARE

Part A: Identifying Information(Mother)

1. Last Name _____ 2. First Name _____
3. Address _____
4. City _____ 5. Zip _____ 6. Parish _____
7. Telephone _____
8. Age _____ 9. Date of Birth / /
mo day yr
10. Race(check): White Black Asian/Pacific Islander Other _____ 11. Ethnicity: Hispanic Non-Hispanic

Part B: Medical Information (Mother)

1. Prenatal care received? Yes No
2. Name of prenatal care provider/clinic name _____ 3. Clinic Phone #: _____
4. Expected delivery date / /
mo day yr
5. Date hepatitis blood drawn / /
mo day yr
HBsAg test result (during this pregnancy): Pos Neg Date: _____
anti-HBs: Pos Neg Date: _____
anti-HBc: Pos Neg Date: _____
6. Expected hospital of delivery _____
7. Expected clinic/provider to care for infant _____

SECTION II: HOSPITAL CARE

Part A: Mother

1. Pregnancy outcome live birth stillborn miscarriage preg. terminated
2. Hospital of delivery _____

Part B: Infant

1. Last Name _____ 2. First Name _____
3. Date of Birth / / 4. Sex Female Male
mo day yr
5. HBIG date / / 6. HBIG time : am/pm 7. 1st dose HBV date / /
mo day yr hr mn mo day yr

Please fax or email form to:

Louisiana Department of Health and Hospitals
Office of Public Health-Immunization Program
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(504) 838-5300
(504) 838-5206 fax
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