HBIG FORM
NMDOH Perinatal Hepatitis B Program
Phone: 505-827-0219, Fax: 505-827-1741

Please complete this information on every newborn receiving hepatitis B immune globulin (HBIG). Please print clearly.

Delivery Hospital ___________________________  Phone __________  Today’s Date ____________
Admit Date/Time ___________________________  Transport: N__ Y___, from ______________________
Prior Prenatal Care: Y______ N___________  Form completed by ____________________________

MOTHER INFORMATION

Last Name _______________  First Name ____________________  Date of Birth _____________________
Medical Record # ________________________  Home Phone _________________
Home address ____________________________  City/State/Zip __________________________
HBsAg Result: Positive____  Neg___  Pending___  If pending, Date/Time Expected ___________
Prenatal provider name ____________________  PN Provider Phone # _______________________

INFANT INFORMATION

Last Name _______________________  First Name ____________________  Gender _________
Date/Time of Birth ____________________  Medical Record # _________________________
Time of birth _________________________  Birth weight (in grams) ___________________
Date/Time HBIG given ___________________  Mfg/Lot# ______________________________
Date/Time Hepatitis B vaccine given _______________ Mfg/Lot# ________________________
Anticipated Pediatrician ____________________  Peds Phone # _________________________
Comments: ________________________________

In accordance with Health Insurance & Accountability Act (HIPAA) Privacy Rule (45CFR 164.512(b)) “covered entities are permitted to disclose public health information, without authorization, to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability.”