

HBIG FORM

NMDOH Perinatal Hepatitis B Program
2400 Wellesley Drive NE
Albuquerque, NM 87107
Phone: 505-841-4692, Fax: 505-841-4104

*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's 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."

