MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

# 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 ProviderPhone # _____

## 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."*

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