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.”