



Perinatal Hepatitis B Pregnancy Report

Birthing facilities should use this form to report Perinatal Hepatitis B births to the NMDOH PHBPP. Include a copy of any lab results.

Fax Completed Form to: **ATTN: PHBPP Coordinator** **Date Faxed:**
505-827-1741

For infants born to HBsAg-positive pregnant persons:

Name of Birthing Facility				
Person Completing Form			Phone	
Pregnant Person's Information				
Last Name		First Name		MI
Date of Birth		Medical Record Number		
Address				
City		Zip	County	
Cell Phone		Home Phone		
Ethnicity	Hispanic	Non-Hispanic	Other	
Race	American Indian/Alaska Native		Asian	Black
	Native Hawaiian/Pacific Islander		White	Unknown
	Other			
Insurance	Medicare	Medicaid	Indian Health Services	Private
	Unknown	Uninsured	Other	
HBsAG Test	Reactive (+) <small>include a copy of report</small>	Unknown	Pending	Date
Antiviral Therapy This Pregnancy	No	Yes	Unknown	
Prenatal Care This Pregnancy	No	Yes	Provider	
Patient Notified of NMDOH Perinatal Hep B Program	Yes	No	Unknown	
Patient Referred to Gastroenterology	Yes	No	Unknown	
Patient Currently Pregnant	Yes	No		
Expected Birthing Facility for Delivery				
Expected Date of Delivery			City	

In accordance with the 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." All responses remain confidential.