San Francisco Department of Public Health

Communicable Disease Prevention Unit - Perinatal Hepatitis B Program

101 Grove Street, Room 406, San Francisco, CA 94102 Ph: 415-554-2834

Edwin Lee, Mayor

DELIVERY ALERT FORM

Date:

Dear Prenatal Care Provider: Please attach this form along with the HBsAg positive lab report to the ACOG Antepartum Record. When the baby is born the birtl hospital staff will complete the form. Thanks.

MOTHER:

First Name Last Name MI DOB

EDD: Case: 38-

Birth Hospital Staff: Please complete and fax to (415) 554-2579.Thanks.

Birth Hospital _______CPMC _______Other (specify) ________

Birth hospital staff completing this form- Name: ___________________________ Ph: ______________

INFANT

Last Name _______________ First Name ________________ Middle Name _______________

Date of birth _____________ Time of birth _______________ (military time)

MR# ___________________ Sex ____ M ____ F Birth weight __________ grams

HBIG given on ____/____/____ (date) at _________________ (military time)

Hepatitis B vaccine given on ____/____/____ (date) at _________________ (military time)

Anticipated pediatrician- Name: ____________________________ Ph: ____________________

INFANT #2, If twins, also complete this information

Last Name _______________ First Name ________________ Middle Name _______________

Date of birth _____________ Time of birth _______________ (military time)

MR# ___________________ Sex ____ M ____ F Birth weight __________ grams

HBIG given on ____/____/____ (date) at _________________ (military time)

Hepatitis B vaccine given on ____/____/____ (date) at _________________ (military time)

Anticipated pediatrician- Name: ____________________________ Ph: ____________________

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