

# HBIG FORM

**Viral Hepatitis Program - Perinatal Hepatitis B Prevention Unit**  
**4300 Cherry Creek Drive South, A-3, Denver, CO 80246**  
**Phone: 303-692-2780, Fax: 303-691-7753**



Colorado Department  
of Public Health  
and Environment

*Please complete the following information on every newborn receiving hepatitis B immune globulin (HBIG).<sup>1</sup> Please print clearly.*

Delivery Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Prior Prenatal Care: Y \_\_\_\_\_ N \_\_\_\_\_

## MOTHER INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Home phone: \_\_\_\_\_

Home address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Obstetrician Name: \_\_\_\_\_ OB Phone #: \_\_\_\_\_

## INFANT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Time of birth: \_\_\_\_\_ Birth weight (in grams): \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Date HBIG given: \_\_\_\_\_ Time Administered: \_\_\_\_\_

Date Hepatitis B vaccine given: \_\_\_\_\_ Time Administered: \_\_\_\_\_

Anticipated Pediatrician: \_\_\_\_\_ Peds Phone #: \_\_\_\_\_

**Please FAX completed form within 24 hours of delivery to: FAX: 303-691-7753**

<sup>1</sup> This information is required as part of an ongoing Hepatitis B investigation by the Colorado Department of Public Health and Environment. Pursuant to Colorado Revised Statute 25-1-122, employees of the CDPHE, when investigating certain reportable diseases and conditions, may, without patient consent, inspect, have access to and obtain patient medical records which are relevant and necessary to the investigation from medical institutions such as yours. Hepatitis B is a reportable disease or condition. Any report or disclosure shall not constitute a violation of any right of privacy or privileged communication.