



MONTANA PERINATAL HEPATITS B PREVENTION PROGRAM PRIMARY REPORT

Send Completed Form to MT PHBPP Coordinator Via Secure File Transfer or Fax to 1-800-616-7460 Within 7 days of Identification of HBsAg Positive Pregnant Woman.

Case Demographic

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Country of Birth: _____

Additional Information:

Hepatitis B Status: Acute Chronic Estimated Date of Delivery: _____

Obstetrical Provider: _____

Anticipated Birth Facility: _____

Anticipated Infant Healthcare Provider: _____

Maternal Insurance Status: Private Public Uninsured Unknown

Additional Forms to be Completed and Faxed to 1-800-616-7460 As Completed

	Due	Date Completed
<input type="checkbox"/> MIDIS Case Investigation	_____	_____
<input type="checkbox"/> PHBPP Primary Report	_____	_____
<input type="checkbox"/> PHBPP Contact Investigation	_____	_____
<input type="checkbox"/> PHBPP Birth Facility Report	_____	_____
<input type="checkbox"/> PHBPP Infant Report	_____	_____

Requirement to Track Hepatitis B Vaccination and Lab Result Status for Infants Born to HBsAg positive Mothers per Administrative Rules of Montana 37.114.540