

## MONTANA PERINATAL HEPATITIS B PREVENTION PROGRAM BIRTH FACILITY REPORT FORM

Must Be Completed and Sent Via Confidential Fax or Other Secure Method to The Local Health Department Within 7 Days Of Delivery

To Be Completed By Local Health Department

10 Be Completed by Local Health Department	
Local Health Department Information	
Local Health Department:	
Contact Name:	Contact Phone Number:
Contact Email:	Confidential Fax Number:
Mother's Information	
Mother's information	
Name:	Date of Birth:
Estimated Date of Delivery:	
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To Be Completed By Birth Facility	
Infant's Information	
Namo	Date of Birth:
Time of Birth:	Birth Weight: ☐ Grams ☐ lbs/oz
Gender: ☐ Male ☐ Female	
Birth Facility Name:	
Birth Facility Contact Name and Number:	
<ul> <li>The following must be administered in separate sites/extremities within 12 hours of birth:</li> <li>Hepatitis B Immune Globulin (HBIG): 0.5mL, IM</li> <li>Hepatitis B Vaccine: 0.5mL, IM</li> </ul>	
HBIG Given: Date	_ Time
	Time
Nurse Signature	Date

Requirement To Report Newborn Infant of a Hepatitis B Surface Antigen (HBsAg) Positive Mother:

Administrative Rules of Montana 37.114.540

Last Update: 05/2025