Perinatal Hepatitis B Pregnancy Report

Fax to: 1-800-334-4931
Attn: Perinatal Hepatitis B Coordinator

Date faxed:

Name of clinic:

Person completing:

Phone:

Client medical record number:

Client information

Last name:

First name:

MI:

Date of birth (mm/dd/yyyy):

Address:

City:

Zip:

County:

Cell phone:

Home phone:

Race:

- ☐ Asian/Pacific Islander
- ☐ Black
- ☐ White
- ☐ American Indian
- ☐ Unknown
- ☐ Other:

Ethnicity:

- ☐ Hmong
- ☐ Somali
- ☐ Vietnamese
- ☐ Hispanic
- ☐ Karen
- ☐ Other:

Insurance status:

- ☐ Medicare
- ☐ Medicaid/State assistance program
- ☐ Indian Health Services
- ☐ Private/HMO/PPO/Managed care plan
- ☐ Unknown
- ☐ Uninsured
- ☐ Other:

Preferred language? ☐ English ☐ Other:

Country of birth?

Is client a refugee? ☐ Yes ☐ No

Dates of HBsAg(+) test (mm/dd/yyyy): Current:

Previous:

Client's provider information

Name:

Provider phone number:

Clinic name and location (city):

Patient currently pregnant? ☐ Yes ☐ No

Estimated date of delivery (mm/dd/yyyy):

Expected location of delivery:

Name of hospital:

City:

Patient notified of hepatitis B result? ☐ Yes ☐ No ☐ Unknown

Notes:

DEPARTMENT OF HEALTH

Perinatal Hepatitis B Prevention Program
P.O. Box 64975, St. Paul, MN 55164-0975
www.health.state.mn.us/hepatitis
651-201-5511

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