

HBIG FORM

Viral Hepatitis Program - Perinatal Hepatitis B Prevention Unit
4300 Cherry Creek Drive South, A-3, Denver, CO 80246
Phone: 303-692-2700 Fax: 303-759-5257



Colorado Department
of Public Health
and Environment

*Please complete the following information on every newborn receiving **hepatitis B immune globulin (HBIG)**.¹ 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: 303-759-5257

¹ 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.