



DC DEPARTMENT OF HEALTH

IMMUNIZATION PROGRAM

PERINATAL CASE REPORT REFERRAL



Prenatal Referrals and Infant cases up to 24 months of age may be reported to the Immunization Program

DATE _____ DELIVERY HOSPITAL _____

REPORTER _____ PHONE _____ EMAIL _____

MOTHER'S INFORMATION**

NAME OF MOTHER _____ DOB _____

ADDRESS _____ PH #(C) _____ (H) _____

RACE: White[] Black[] Asian[] Am Indian[] Other[] _____ ETHNICITY: Hisp [] Non-Hisp []

EST DELIVERY DATE _____ OBSTETRICIAN _____ PH _____

HEP B LAB RESULTS: HBsAg = _____ HBcAb= _____ HBeAg= _____ HBV-DNA _____

Was mother given prenatal antiviral Hep B therapy during this pregnancy? Y[] start date _____ N[] unkn[]

NAME OF FATHER _____ Ph# _____

NEWBORN/CHILD INFORMATION**

NAME _____ M[] F[] DOB _____ TIME of BIRTH _____ WT _____

HBIG GIVEN DATE _____ TIME _____ NO[] **HEP B#1 GIVEN** DATE _____ NO[]

Mult Birth N[] Y[] Name of INFANT #2 _____ M[] F[] WT _____

HBIG GIVEN DATE _____ TIME _____ NO [] **HEP B#1 GIVEN** Y [] DATE _____ NO []

PEDIATRICIAN NAME _____ PH _____ FX _____

Please attach any vaccination records and Hep B serology labs of mother and new pediatric cases referred

Send all case referrals to the DC DOH **ATTN: PERI HEP B NURSE** at fax 202-576-6418.

Call Donna Sheler, RN 202-576-9325 or email doh.phbcases@dc.gov for confirmation of fax receipt or questions.

FOR OFFICIAL USE:

Date received _____ QB CASE# _____ QB CASE# _____