

**County of Santa Clara  
Public Health Department**

Communicable Disease Prevention and Control  
Perinatal Hepatitis B Prevention Program  
976 Lenzen Avenue, 1<sup>st</sup> Floor, Suite 1200  
San Jose, CA 95126  
Tel: (408) 885-4214 Fax: (408) 792-1304



**Perinatal Hepatitis B Prevention Program Referral**

To refer an HBsAg-positive woman who is pregnant or has recently delivered to the Perinatal Hepatitis B Prevention Program (PHBPP) for case management, please complete and fax this form to **408-792-1304**.  
Note: Remember to check the risk factors below.

Patient's Name ( <i>Last, First, Middle</i> )		Gender F	Date of Birth	SCVMC MR #
<b>HBsAg (Hep B surface antigen) Result</b> Date of Test _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<b>HBeAg (Hep B e antigen) Result</b> Date of Test _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Tested		<b>Hepatitis B Viral Load</b> Date of Test _____ <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Unknown
<input type="checkbox"/> Pregnant <input type="checkbox"/> Recently Delivered		Estimated/Actual Delivery Date (month/day/year):		Planned/Actual Delivery Hospital
<b>Check All Known Hepatitis B Related Risk Factors:</b>				
<input type="checkbox"/> Teen mother		<input type="checkbox"/> History of noncompliance		
<input type="checkbox"/> Mother is newly infected (new hepatitis B converter)		<input type="checkbox"/> Previous child/children infected with Hep B virus		
<input type="checkbox"/> Mother lacks hepatitis B knowledge		<input type="checkbox"/> Infant's birth weight under 2000g (4.4 lbs)		
<input type="checkbox"/> Mother has high Hep B viral load/is highly infectious		<input type="checkbox"/> Missed/delayed HBIG and/or HBV#1 for infant		
<input type="checkbox"/> Other (specify):				
Patient's Address				
Best way to contact your patient is:		Insurance: (√ one)		S.S.N.
Home _____		<input type="checkbox"/> Medi-Cal		Race /Ethnicity
Work _____		<input type="checkbox"/> Govt. 3 <sup>rd</sup> party payer		
Cell _____		<input type="checkbox"/> Private		Can this patient read English? <input type="checkbox"/> Yes (If no, please state preferred language): _____ <input type="checkbox"/> No
E-mail _____		<input type="checkbox"/> Self-pay		
		<input type="checkbox"/> Low Income		
		<input type="checkbox"/> Unknown / Other		

X \_\_\_\_\_  
Referring Provider/Physician's Name (printed or stamped)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

*Hepatitis B infection is one of the diseases listed in The California Code of Regulations that health care providers are required to report to the local public health department. Mandated public health reporting is exempted from HIPAA restrictions; patient consent is not required.*