

PROVIDER REPORTING FORM

Please complete this form each time a dose of hepatitis B (hepB) vaccine is administered to an infant whose mother has tested hepatitis B surface antigen-positive (HBsAg-positive), or to her household or sexual contacts. Please mail this form to MDCH, Detroit Regional Office, 3056 West Grand Boulevard, Suite 3-150, Detroit, MI 48202, fax it to 313-456-0639, email it to PhillipsA3@michigan.gov or call the Perinatal Hepatitis B Prevention Program (PHBPP) with the information to 313-456-4432. Also, please update the child's Michigan Care Improvement Registry (MCIR) record.

_____ DOB _____

Was post-vaccination tested?

Date: _____

PLEASE RETURN WITH A COPY OF THE LABORATORY RESULTS

(Circle test results)

HBsAg: **Positive*** **Negative**

- * A positive test indicates infection with the hepatitis B virus (HBV).
Desired result is negative.

Anti-HBs: **Positive*** **Negative**

- * A positive test indicates protection against the HBV.
Desired result is positive.

---Tear off-----

_____ received his/her final dose (**6 months or after**) of hepB vaccine.

Date: _____

Recombivax HB ____ Engerix-B ____ Pediarix ____

Doctor's name or stamp: _____

---Tear off-----

_____ received his/her **second** dose of hepB vaccine.

Date: _____

Recombivax HB ____ Engerix-B ____ Pediarix ____

Doctor's name or stamp: _____