

Perinatal Hepatitis B Pregnancy Report

Clinics should use this form to report pregnant women who are hepatitis B carriers to the Minnesota Department of Health.

Fax to: (651) 201-5502
Perinatal Hepatitis B Coordinator
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Person Completing: _____

Phone: (_____) _____

Date Faxed: ____ / ____ / ____

Medical Record #: _____

Client Information		Dates of HBsAg(+) Test: Current ____/____/____ Previous ____/____/____	
Last Name: _____		First Name: _____	MI: _____
Address: _____		City: _____	Zip Code: _____
County: _____		Home Phone: () _____	
Date of Birth: _____		Work Phone: () _____	
Insurance Status: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Unknown			
Is Client English Speaking? Yes No Is Client Foreign Born? Yes No If Yes: Country of Origin: _____ Is Client a Refugee? Yes No	Race: <input type="checkbox"/> Asian/ Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	Ethnicity: <input type="checkbox"/> Hmong <input type="checkbox"/> Somali <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hispanic <input type="checkbox"/> Other (specify): _____	
Client's Physician Information:		Currently Pregnant? Yes No	
Name: _____		Estimated Date of Delivery: ____/____/____	
Clinic Name: _____		Expected Location of Delivery:	
Location of Clinic (City): _____		Name of Hospital: _____	
Physician Phone #: (_____) _____		City: _____	
Carrier Status Based On: _____		Does Client Know She's A Carrier? Yes No Unknown	
Notes: 			