



EPID 399

Rev. 7/2024

Kentucky Public Health
Prevent. Promote. Protect.

Kentucky Reportable Disease Form
Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001
Perinatal Hepatitis B Prevention Form for
Exposed Infants and Hepatitis B Positive Pregnant Mothers
Fax Form to Residing Health Department or
502-696-3803 or 855-568-8601

PREGNANT/ POST PARTUM MOTHER INFORMATION							
Mother's Current Legal Name: Last: First: M.I.:			Is Patient Pregnant: Yes No Expected Date of Delivery: / /		Is Patient Post-Partum: Yes No If Yes, Date of Delivery: / /		
Address:			City:		State:		Zip:
Mother's Date of Birth: / /		County of Residence:		Race: * W B A AI PI		Telephone Number:	
Social Security #:		Ethnic Origin: Hispanic Non-Hispanic		Insurance Status: Private Uninsured Medicaid Unknown		Other Pertinent Information:	
Obstetrician's Name:		Obstetrician's Address:			Hospital for Delivery: Address:		
* Race: W – White B – Black A – Asian AI – American Indian or Alaska Native PI – Pacific Islander							
MOTHER'S HBsAG TESTING							
Date of HBsAG results received: / / Results: Positive Negative Unknown			• Notify the Infection Preventionist in your facility if the mother is HBsAg-positive • Fax copy of EPID 399 and copy of lab results to residing health department within 1 day of birth				
HEPATITIS B EXPOSED INFANT INFORMATION							
Infant/Child Name: Last: First:		Date of Birth: / /	Gender: Male Female		Hospital Name:		Hospital Phone Number:
Address:		City:		Infant/Child lives with: Mother Foster Parent Adopted Other: _____			
State:		Zip:					
Weight at Birth:		Insurance Status: Private Uninsured Unknown Medicaid			Is the Department Community Based Services Involved: Yes No If Yes, Case Number:		
Time of Birth:							
Administer 0.5 mL monovalent Hepatitis B vaccine and 0.5 mL HBIG within 12 hours of birth to infants							
• Born to HBsAg-positive mothers • Infants born to mothers with an unknown HBsAg status • Fax copy of EPID 399 to residing health department within 1 day of birth							
Biological Administered	Date	Time	Dosage	Site of Injection	Manufacturer & Lot Number	VIS Pub Date	RN Signature
Hepatitis B Vaccine	/ /		0.5 mL			/ /	
HBIG	/ /		0.5 mL			/ /	
PARENT CONSENT/REFUSAL		Signature:			Reason:		Date: / / / / / /
							Time: