EPID 399
Rev. 5/2025

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 P I	Telephone Number:	
Social Security #:	Ethnic Origin: Hisp. Non-Hisp.	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: State: Zip:		Infant/Child lives with: Mother Foster Parent Adopted Other: _____		
Weight at Birth: Time of Birth:	Insurance Status: Private Uninsured Unknown Medicaid	Is the Department Community Based Services Involved: Yes No If Yes, Case Number:		

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: