COMMONWEALTH of VIRGINIA

Department of Health

PO BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

VIRGINIA PERINATAL HEPATITIS B PREVENTION PROGRAM
HBsAg Positive Pregnant Woman Reporting Form
(Please include copy of positive lab)

1. Patient's Name: _____
2. Social Security Number: _____/_____/_____
3. Patient's Address: _____
4. City or County of Residence: _____
5. Home Phone: _____ Work Phone: _____
6. Date of Birth: _____
7. Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Other:_____
8. Birth Country: _____
9. Estimated Date of Delivery:_____
10. Delivery Hospital: _____
11. Insurance Status (For statistical purposes only):

    ☐Private – Include CHIP Programs ☐Public (Medicaid) ☐Uninsured ☐Unknown
12. Has patient been notified concerning her positive test result? ☐Yes ☐No
13. Additional Information (Language Spoken, etc):_____

Provider Name *(Please Print)*: _____

Address: _____

Phone Number: _____

Provider Signature: _____

Thank You Very Much For Your Time
Fax: 804-864-8089

Rev. 04/12

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov