



COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

B. Cameron Webb, MD, JD
State Health Commissioner

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

VIRGINIA PERINATAL HEPATITIS B PREVENTION PROGRAM

HBsAg Positive Pregnant Woman Referral Form
(Please include copy of positive lab)

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

**Please fax this form to
804-864-7259**