**Perinatal Hepatitis B Prevention Letter to Exposed Infant’s Provider**

**Place on Local Health Department Letterhead**

Date:

Physician’s name

Address

**Re: Jane Doe DOB: 1/1/10**

Dear Doctor,

This child was born to a hepatitis B surface antigen (HBsAg)-positive mother and therefore is at high risk for perinatal hepatitis B transmission. For this reason, the child is enrolled in case management with the Perinatal Hepatitis B Prevention Program of (county’s HD name). Because of this infant’s perinatal exposure to hepatitis B virus, she/he received hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine at birth. The remainder of the hepatitis B vaccine series and post-vaccination serologic testing (PVST) needs to be completed according to the American Academy of Pediatrics’ Recommended Schedule for Hepatitis B Immunoprophylaxis to Prevent Perinatal Transmission***.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Infant 2,000 grams or more** | **Infant < 2,000 grams** | | HepB dose #1 and HBIG within 12 hours of birth | HepB dose #1 and HBIG within 12 hours of birth | | HepB dose #2 at 1 through 2 Months of age | HepB dose #2 at 1 month after birth dose. | | HepB dose #3 at 6 months of age | HepB dose #3 at 1 to 2 months after HepB dose #2 | |  | HepB dose #4 at 6 months of age | | Postvaccination serologic testing for hepatitis B surface antigen (HBsAg) and quantitative antibody to hepatitis B surface antigen (quantitative anti-HBs) should be ordered at age 9 through 12 months  (or 1 through 2 months after the final dose of the vaccine series, if delayed). | | |

A case management form is enclosed. Please place this in the infant’s chart and fax the form back to XXXX at XXX-XXX-XXXX after each vaccination and after post-vaccination serology testing with a copy of the lab results.

Please contact XXX at XXX-XXX-XXXX if you have any questions regarding the Perinatal Hepatitis B Prevention Program or what services are needed for your enrolled patient.

Sincerely,

XXXXXX

Perinatal Hepatitis B Prevention Coordinator of XXXXX County