Kansas
Department of Health and Environment

PRENATAL CARE PROVIDER REPORT FORM
PERINATAL HEPATITIS B PREVENTION

Please complete the form with as much information as possible and FAX to the Perinatal Hepatitis B Prevention Program at **1-877-427-7318**.

PROVIDER'S NAME_____PROVIDER'S PHONE NUMBER (____)_____

ADDRESS _____

TODAY'S DATE _____ / _____ / _____

MOTHER'S INFORMATION

Last Name:	First Name:
Date of Birth: / /	HBsAg positive test date: / /
Address:	
City:	Zip Code:
Contact Phone #: ( )	Alternative Phone #: ( )
Anticipated Delivery Hospital:	
Estimated Delivery Date: / /	
Anticipated Pediatrician Name:	
Anticipated Pediatrician Phone #: ( )	
Insurance: ☐ Medicaid ☐ Private Insurance ☐ Uninsured ☐ Other (please specify) _____	

Race: (check all that apply)		Hispanic Ethnicity:
☐ African American or Black	☐ Caucasian or White	☐ Yes
☐ American Indian or Alaskan Native	☐ Native Hawaiian or Other Pacific Islander	☐ No
☐ Asian	☐ Race, not otherwise specified	

For questions or more information please call (785) 368-8208.