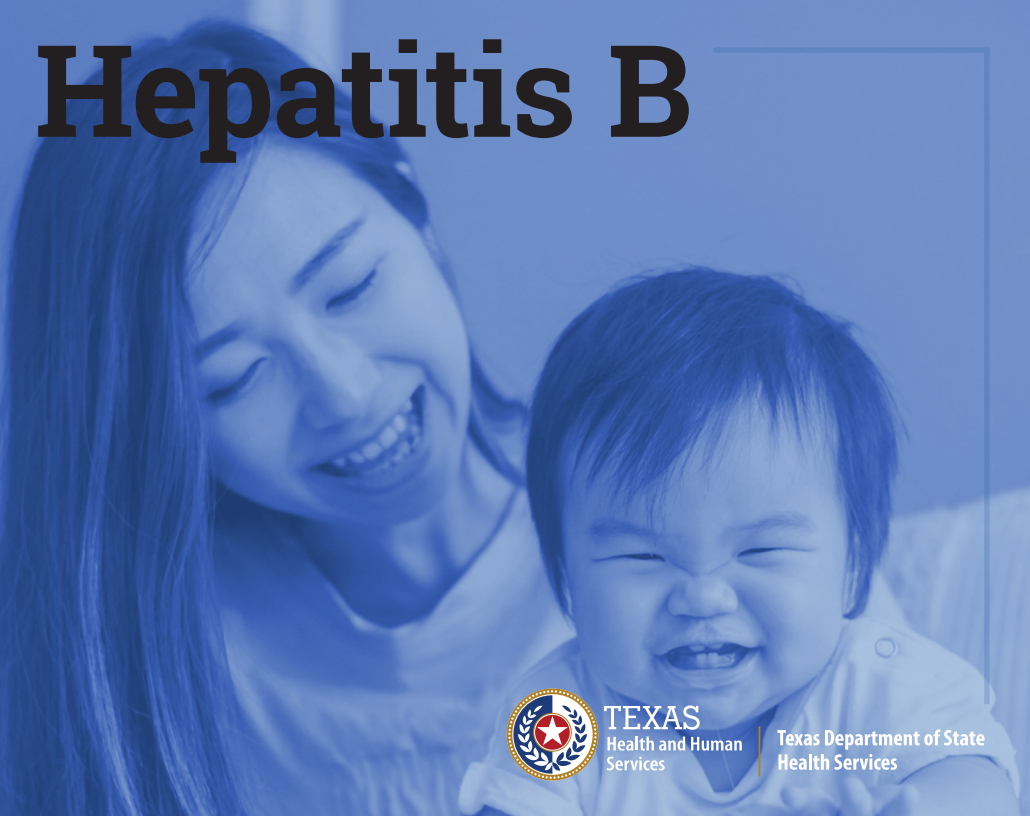


Hepatitis B



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Present this card to your nurse in the hospital's delivery area before the birth of your baby. Ask your nurse to complete the information on this card.

Patient Name: _____

Address: _____

City: _____

Hospital Name: _____

Physician: _____

Phone: _____

I had a positive Hepatitis B Surface Antigen (HBsAg) test.

Physician: _____

Date: _____ Phone: _____

Lab Name: _____

Upon hospital admission and prior to delivering my baby, I need a second HBsAg test.

Baby's Name: _____

Date of Birth: _____ Time of Birth: _____

Birth Weight: _____ Gestational Age: _____

My baby needs to receive the following within 12 hours after birth:

Hepatitis B immune globulin (HBIG)
Date Given: _____ Administered by: _____

Time Administered: _____

Hepatitis B vaccine first dose
Date Given: _____ Administered by: _____

Time Administered: _____

Mailing Address:

Attn: Perinatal Hepatitis B Prevention Program
Texas Department of State Health Services
Immunizations Section
Mail Code 1946 P.O. Box 149347
Austin, Texas 78714-9347

[dshs.texas.gov/immunizations/
what-we-do/vaccines/hepatitis-b](https://dshs.texas.gov/immunizations/what-we-do/vaccines/hepatitis-b)
Tel: 800-252-9152
Fax: 512-776-7544

Texas Department of State Health Services
Immunizations Section
Stock # F11-11539 Rev. 11/2024

Hepatitis B



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Presente esta tarjeta a su enfermera en el área de partos del hospital antes de que nazca su bebé. Pídale a su enfermera que rellene la información en esta tarjeta.

Nombre del paciente: _____

Dirección: _____

Ciudad: _____

Nombre del hospital: _____

Médico: _____

Teléfono: _____

Mi análisis de antígeno superficial de hepatitis B (HBsAg) resultó positivo.

Médico: _____

Fecha: _____ Teléfono: _____

Nombre del laboratorio: _____

Al ser ingresada al hospital y antes de dar a luz, necesito que me hagan un 2.o análisis de HBsAg.

Nombre del bebé: _____

Fecha de nacimiento: _____ Hora de nacimiento: _____

Peso al nacer: _____ Edad gestacional: _____

Mi bebé necesita recibir lo siguiente dentro de las 12 horas siguientes al nacimiento:

Inmunoglobulina antihepatitis B (HBIG)
Fecha dada: _____ Administrada por: _____

Hora en que se administró: _____

Hepatitis B vacuna: la primera dosis
Fecha dada: _____ Administrada por: _____

Hora en que se administró: _____

Dirección de correo:

Attn: Perinatal Hepatitis B Prevention Program
Texas Department of State Health Services
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