Date

Dear Dr. XXXXXXXXXX:

The following patient, seeking treatment at your practice, is a contact to case of Hepatitis B, and is being tracked by the (Local Health Department) Hepatitis B Prevention Program.

Contact's Name: **Baby Girl XXX** DOB: **XX/XX/XXXX** Mother's Name: **Mother XXXX**

The local health department will be working closely with you to ensure that the patient is protected against this serious disease. The local health department will actively refer the patient when vaccines are due and confirm vaccination dates & test results with your office. Please see the Immunization Record or Impact SIIS for the HBIG and the hepatitis B vaccine given at the time of birth.

The relationship to the case: **Neonate of an HBsAg Positive Mother**

**DUE TO THE INFANT'S BIRTHWEIGHT BELOW 2000 GRAMS, FOUR DOSES ARE REQUIRED--- basically the one at birth is not counted towards the 3 doses needed to complete the series.**

The infant's **second** dose of Hepatitis B vaccine is due XX/XX/XXXX (one month after the hospital dose, single antigen, or at 6 weeks of age for a combination vaccine)
The infant's **third** dose of Hepatitis B vaccine is due XX/XX/XXXX**.**
The infant's **fourth** dose of Hepatitis B vaccine is due XX/XX/XXXX**.**

Administration of a three dose Hepatitis B Vaccine series in <2000 Gram babies is at **1, 2, and 6 months of age.** The first dose (not counted as part of the series of 3) is normally given at the hospital within 12 hours of the birth along with a dose of HBIG.

***If 1, 2, and 6 months schedule is DELAYED as a result of missed appointments:***

There must be at least **one month** between the **first and second dose**
There must be **two months** between the **second and third dose,** but **four months** between the **first and third dose**
The **third dose** can be given **no earlier than 6 months of age** (which meets the school entry requirement)

**A post vaccine serology should be drawn 3-6 months after the LAST dose, consisting of a HBsAg and a quantitative anti-HBs.** These tests can not be done before 9 months of age.

Please call (Your Name, RN, PHN) at the (Local Health Department) at XX/XX/XXXX or FAX: XX/XX/XXXX with the date of each Hepatitis B vaccination and with the post vaccine serology results.

Sincerely,

Your Name, RN, PHN
Local Health Department
Perinatal Hepatitis B Prevention Program