UTAH DEPARTMENT OF HEALTH
IMMUNIZATION PROGRAM
PERINATAL HEPATITIS B PREVENTION PROJECT
LABORATORY TESTING FORM

Collection Date_____ Form Number_____
mm/dd/yy

Testing will not be performed unless form is completely filled out. Blood specimen accompanying this form must be labeled with the patient's name and form number.

PATIENT INFORMATION

Type of Patient & Serological Test ☐ Pregnant HBsAg ☐ Contact HBsAg & Anti-HBs ☐ Newborn Follow-up. 9-12 months, HBsAg & Anti-HBs

Specimen source: ☐ Serum ☐ Other_____

Patient Name _____ DOB ____/____/____ Sex_____

Street Address _____ Home Phone _____

City, State, Zip _____ Work Phone _____

ETHNICITY:

☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black
☐ Hispanic ☐ Pacific Islander ☐ White ☐ Other

If pregnant, Estimated Date of Delivery _____/_____/_____

If contact or newborn, Name of HBsAg + mother_____

INSURANCE STATUS: ☐ Uninsured ☐ Underinsured – client cannot afford

PROVIDER INFORMATION

Provider Code ☐☐☐☐ (If known) Route

Facility or location where specimen was drawn:

Facility Name _____
Street Address _____
City, State, Zip _____
Phone _____

Person submitting testing form:

Name _____
Title _____
Facility _____
Phone _____
Date Submitted _____/_____/_____

COMMENTS, SPECIAL INSTRUCTIONS, OR CLARIFICATION

(Results will be sent to the person submitting the testing form and to the Immunization Program unless specified below.)

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Scan completed form and attach PDF to electronic perinatal case record for mother/contact in EpiTrax.

Send **original form** with specimen to Unified State Laboratories, 4431 South Constitution Blvd., Taylorsville, Utah 84129. Phone 801-965-2400. Unified State Laboratories bills the Utah Department of Health, Immunization Program (801-538-9450) directly for serological testing.

(This form may be downloaded online at www.immunize-utah.org) 2/21/18