Post-Vaccine Serology (PVS) Results Form

Please complete and return this form by fax or email:

Fax: 213-351-2781 **Click to Email Form**

INCLUDE PVST LAB REPORTS WHEN SUBMITTING THIS FORM

Patient's Name: _____ **DOB:** _____

Results of PVS Testing and Follow-Up ***(check one)***

☐ **Patient is immune – no additional follow-up is needed***:*

- HBsAg is non-reactive
- Anti-HBs is ≥ 10 mIU/mL

☐ **Patient is susceptible – needs 1 additional dose of HepB vaccine & PVST 1-2 months later**:

- HBsAg is non-reactive
- Anti-HBs is <10 mIU/mL

☐ **Patient is infected – refer to pediatric gastroenterologist**:

- HBsAg is reactive, *regardless of Anti-HBs results*

If patient is **infected**, was infant referred to a specialist? Yes ☐ No ☐ Unknown ☐

If yes, please provide the pediatric gastroenterologist's name and phone number:

Name of Gastroenterologist: _____

Phone Number: _____

If no, document why in Additional Notes below.

☐ **Patient is no longer in my care:**

Patient's current pediatrician (if known): _____

Phone Number: _____

☐ **Parent refused PVS testing – document why in Additional Notes**

Additional Notes:

Name of Physician Completing Form: _____

Phone Number: _____ **Email:** _____

Fax Number: _____ **Date Submitted:** _____

Revised 2026-07-10