

Post-Vaccine Serology (PVS) Results Form

Please complete and return this form by fax or email:

Fax: 213-351-2781

Email:



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:** _____

The information will be used only for **necessary** public health follow-up as defined in **Division 1 and 4 of the State Health and Safety Code for communicable disease control. Public health reporting is exempted from HIPAA restrictions.** The information contained is confidential and is intended only for the use of the recipient listed above. If you are neither the intended recipient or the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.