Pregnancy Verification Form

Please complete and return this form by fax or email:

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

INCLUDE ALL AVAILABLE HEPATITIS B LAB RESULTS FOR THIS PATIENT FOR THIS PREGNANCY, IF APPLICABLE

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

Please indicate the patient's pregnancy status:

☐ **Yes**, patient is pregnant.

If patient is pregnant, please fill out the below information to the best of your ability:

Patient Address:_____

Phone Number: _____ Expected Date of Delivery (EDD):_____

Primary Language That Patient Speaks: _____

Delivery Hospital: _____

OB Name: _____ OB Phone Number: _____

☐ **No,** patient is **not** pregnant.

☐ **Unknown**

Additional Notes (if needed):

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.

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