



Perinatal Hepatitis B Prevention Program In-State Case Transfer Form

This form is for case transfers within California.

County of Transfer Information: _____
Name of County

Name of Coordinator _____

E-mail _____ Phone (_____) _____

Fax (_____) _____

Date of Transfer ____ / ____ / ____

Case Transfer ID number _____
co mm yy

County of Origin Information: _____
Name of County

Name of Coordinator _____

E-mail _____ Phone (_____) _____

Fax (_____) _____

Name of Mother _____ Name of Infant _____

New Contact information _____

Date of Transfer ____ / ____ / ____

Case ID Number _____
co mm yy

The State Perinatal Hepatitis B Program HAS HAS NOT been notified of this transfer

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| Instructions: | <ul style="list-style-type: none"> • This form is for case transfers within the state. • Both counties (County of Transfer and County of Origin) should keep a copy of this transfer form in their respective records. • For County of Transfer - Send completed form to County of Origin to acknowledge receipt of transfer. • For County of Origin - If form has <u>not</u> been received within 2 weeks from date of transfer, then follow-up with the coordinator in the County of Transfer. |
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