

Acute Hepatitis B

_____ COUNTY

FOR STATE USE ONLY

___/___/___ case report

confirmed

___/___/___ interstate

presumptive

suspect

date investigation initiated ___/___/___

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

_____ language spoken _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

INITIAL SOURCE OF REPORT

Lab: ELR ICP
 Phone call Physician
 Fax _____

Name _____

Phone _____ Date ___/___/___
(first report) m d y

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX female male

HISPANIC yes no unknown

DATE OF BIRTH ___/___/___
m d y

or, if unknown, AGE _____

PLACE OF BIRTH

USA
 other _____

RACE

White American Indian or Alaska native
 Black unknown
 Asian refused to answer
 Native Hawaiian or Pacific Islander other _____

Worksites/school/day care center

Occupations/grade

BASIS OF DIAGNOSIS

CLINICAL DATA

DIAGNOSIS DATE ___/___/___
m d y

Symptomatic? yes no unknown

if yes, ONSET DATE (first s/s) ___/___/___
m d y

Jaundiced yes no ___/___/___

Pregnant yes no ___/___/___
due date

Hospital Name: _____

Hospitalized from hepatitis yes no ___/___/___
admit date

Died from hepatitis yes no

Date of death ___/___/___

REASON FOR TESTING (check all that apply)

- Symptoms of acute hepatitis
- Screening of asymptomatic patient with reported risk factors
- Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- Prenatal screening
- Evaluation of elevated liver enzymes
- Blood/organ donor screening
- Followup testing for previous marker of viral hepatitis
- Unknown
- Other _____

LABORATORY TESTS

Lab Name: _____

Date of blood draw ___/___/___
m d y

pos. neg. pending not done

IgM anti-HAV

total anti-HAV

HBsAg

IgM anti-HBc

total anti-HBc

anti-HBs

HBV DNA (PCR)

HBeAg

Anti-HCV

Anti-HCV signal-to-cutoff ratio _____

RIBA

HCV RNA (PCR)

HCV genotype _____

Other _____

Has the patient previously tested HBsAg-positive?

yes no unknown

if yes, when? ___/___/___
m d y

Upper limit normal Date of test
m/d/y

(list reference value from lab slips)

ALT (SGPT) _____

AST (SGOT) _____

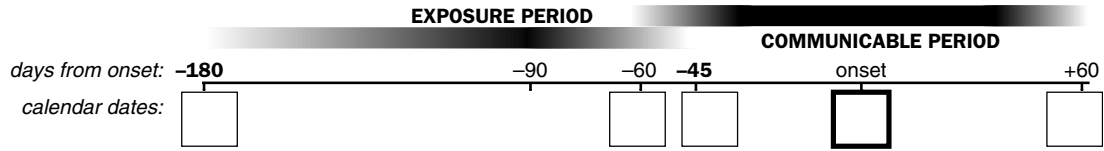
Bilirubin _____

other tests (specify)



INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



(infectious until clearance of HBsAg—about 60 days for most adults—
indefinitely for carriers)

EPI LINKAGE

During the 6 weeks to 6 months prior to onset, was the patient

- associated with a known outbreak
- a close contact of an infectious **confirmed** or **presumptive** case

Was this case reported? yes not yet

Specify nature of contact: household sexual needle use perinatal _____

If case is <2 years old, was hepatitis B acquired as a result of perinatal transmission?

yes no unknown Mother's name _____

If yes to any question, specify relevant names, dates, places, etc.

IMMUNIZATION HISTORY

Did patient ever complete a three-shot hepatitis B immunization series?

yes no unknown

If yes, provide details (dates, type of vaccine, etc.)

Vaccine Type	Date	Provider/Phone	Verified
			yes no
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>

Was the patient tested for antibody to HBsAg (anti-HBs) after the last dose?

yes no unknown

If yes, was serum anti-HBs ≥ 10 mIU/ml?

yes no unknown

(answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

- probable recent infection** (ask about potential exposures in the 45 to 180 days prior to onset).
- probable carrier** (ask about any significant potential exposures, e.g. previous IV drug use, multiple sexual partners, etc.)

Check all that apply: no risk factor identified patient could not be interviewed

Did any of the situations below apply to the case in the 6 weeks to 6 months prior to onset of symptoms?

- | | | |
|--|---|--|
| <p>yes no</p> <p>a <input type="checkbox"/> <input type="checkbox"/> organ transplant/artificial insemination</p> <p>b <input type="checkbox"/> <input type="checkbox"/> IG recipient (any kind: IVIG, TIG, HBIG, etc.)</p> <p>c <input type="checkbox"/> <input type="checkbox"/> hemodialysis patient</p> <p>d <input type="checkbox"/> <input type="checkbox"/> needlestick or similar injury</p> <p>e <input type="checkbox"/> <input type="checkbox"/> had other exposure to someone else's blood (specify) _____</p> <p>f <input type="checkbox"/> <input type="checkbox"/> transfusion/other blood product recipient
if yes, date (m/d/y) ____/____/____</p> <p>g <input type="checkbox"/> <input type="checkbox"/> receive any infusions or injections in the outpatient setting</p> <p>h <input type="checkbox"/> <input type="checkbox"/> uses street drugs but does not inject</p> <p>i <input type="checkbox"/> <input type="checkbox"/> injects drugs not prescribed by doctor</p> <p>j If yes, primary drug injected (select only one):
<input type="checkbox"/> Methamphetamine/Speed
<input type="checkbox"/> Heroin
<input type="checkbox"/> Cocaine
<input type="checkbox"/> Speedball (cocaine & heroin together)
<input type="checkbox"/> Other _____</p> <p>k Year of most recent injection drug use (if applicable):
_____</p> <p>l <input type="checkbox"/> <input type="checkbox"/> employed in medical/dental field involving direct contact with human blood
if yes, frequency of direct blood contact
<input type="checkbox"/> frequent (several times weekly)
<input type="checkbox"/> infrequent</p> | <p>yes no</p> <p>m <input type="checkbox"/> <input type="checkbox"/> employed as public safety worker (fire, police, corrections) having direct contact with human blood
if yes, frequency of direct blood contact
<input type="checkbox"/> frequent (several times weekly)
<input type="checkbox"/> infrequent</p> <p>n <input type="checkbox"/> <input type="checkbox"/> tattooing
if yes, where was it done?
<input type="checkbox"/> commercial parlor/shop
<input type="checkbox"/> correctional facility
<input type="checkbox"/> self
_____</p> <p>o <input type="checkbox"/> <input type="checkbox"/> body piercing (other than ear)
if yes, where was it done?
<input type="checkbox"/> commercial parlor/shop
<input type="checkbox"/> correctional facility
<input type="checkbox"/> self
_____</p> <p>p <input type="checkbox"/> <input type="checkbox"/> dental work or oral surgery</p> <p>q <input type="checkbox"/> <input type="checkbox"/> other surgery?</p> <p>r <input type="checkbox"/> <input type="checkbox"/> hospitalized?</p> <p>s <input type="checkbox"/> <input type="checkbox"/> resident of long-term care facility</p> <p>t <input type="checkbox"/> <input type="checkbox"/> incarcerated for more than 24 hours
if yes, in what type of facility
<input type="checkbox"/> prison
<input type="checkbox"/> jail
<input type="checkbox"/> juvenile facility</p> | <p>yes no</p> <p>u <input type="checkbox"/> <input type="checkbox"/> any sexual contact if yes, number of male sexual partners
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> unknown</p> <p>number of female sexual partners
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> unknown</p> <p>During his/her lifetime, was patient EVER</p> <p>v <input type="checkbox"/> <input type="checkbox"/> incarcerated more than 6 months
if yes, year of most recent incarceration
_____ for how many months
_____</p> <p>w <input type="checkbox"/> <input type="checkbox"/> treated for a sexually transmitted disease
if yes, year of most recent treatment
_____</p> <p>Provide details (by letter) for any risk factor(s) identified. Include names, dates, places, circumstances, etc., as applicable.</p> |
|--|---|--|



CASE-CONTACT AND PERINATAL CASE MANAGEMENT / FOLLOW-UP

Case education provided? yes no unknown
 if yes, date ____/____/____
 Is the patient pregnant? yes no
 Trimester when screened 1st 2nd 3rd

If patient is currently pregnant: due date ____/____/____
 Should she be retested prior to delivery? yes no
 Was an infant tracking file established? yes no
 Was mom counselled about pregnancy risks? yes no

If patient is pregnant, please complete the additional infant information on the hepatitis B perinatal case management form.

Identify other potential concerns; provide details below:

- excessive drooling, biting, or bleeding recent blood/plasma donation HCW performing invasive procedures

HOUSEHOLD ROSTER/OTHER CONTACTS

Ask about other potential contacts (sexual, needle-sharing, etc.) within the period of communicability.

- no other contacts identified contacts identified and individual case report forms file

PROPHYLAXIS

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended?
_____	_____	_____	____/____/____ <small>m d y</small>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> yes by proxy <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> immune <input type="checkbox"/> insignificant <input type="checkbox"/> NA exposure If yes, date recommended: ____/____/____ <small>m d y</small>
Prophylaxis given: <input type="checkbox"/> Referred to HCP <input type="checkbox"/> Refused <input type="checkbox"/> HBIG <input type="checkbox"/> Vaccine <input type="checkbox"/> None						Date prophylaxis given (if applicable): ____/____/____ <small>m d y</small>

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Prophylaxis given: <input type="checkbox"/> Referred to HCP <input type="checkbox"/> Refused <input type="checkbox"/> HBIG <input type="checkbox"/> Vaccine <input type="checkbox"/> None						Date prophylaxis given (if applicable): ____/____/____ <small>m d y</small>

Notes

ADMINISTRATION

Completed by _____ Date Completed _____ Phone _____ Case report sent to OHS on ____/____/____
 Investigation sent to OHS on ____/____/____