

# Chronic Hepatitis B

\_\_\_\_\_ COUNTY

date investigation initiated \_\_\_/\_\_\_/\_\_\_

FOR STATE USE ONLY

# \_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_ case report

confirmed

\_\_\_/\_\_\_/\_\_\_ interstate

presumptive

suspect

## CASE IDENTIFICATION

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) OK to talk to patient?

Phone \_\_\_\_\_

## DEMOGRAPHICS

SEX  
 female  male

HISPANIC  
 yes  no  unknown

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_  
m d y  
or, if unknown, AGE \_\_\_\_\_

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

PLACE OF BIRTH  
 USA  
 other \_\_\_\_\_

Worksites/school/day care center  
\_\_\_\_\_  
\_\_\_\_\_

Occupations/grade  
\_\_\_\_\_  
\_\_\_\_\_

## BASIS OF DIAGNOSIS

### CLINICAL DATA

DIAGNOSIS DATE: \_\_\_/\_\_\_/\_\_\_

Symptomatic?  yes  no  unk  
if yes, ONSET DATE, (first s/s) \_\_\_/\_\_\_/\_\_\_

Pregnant?  yes  no  \_\_\_\_\_  
due date

Name of Hospital \_\_\_\_\_  
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 \_\_\_\_\_ (specify)

### LABORATORY TESTS

Name of Lab \_\_\_\_\_

Date of blood draw \_\_\_/\_\_\_/\_\_\_  
pos. neg. pending not done

IgM anti-HAV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
total anti-HAV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IgM anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

total anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HBV DNA(PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HBeAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-HCV signal-to-cutoff ratio	_____			

RIBA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
------	--------------------------	--------------------------	--------------------------	--------------------------

HCV RNA (PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCV genotype	_____			

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	_____	_____	___/___/___

### TREATMENT DATA

Is patient seeing a provider (i.e. PCP, gastrointestinal or liver specialist) for management of their chronic hepatitis B infection?  
 yes  no  unk

Has patient ever taken any medication (including interferons, nucleoside analogues) prescribed by a medical doctor for chronic hepatitis B?  
 yes  no  unk

Has patient ever had a liver transplant?  
 yes  no  unk

Is patient waiting for a liver transplant?  
 yes  no  unk



PATIENT'S NAME ▶

[Empty box for patient name]

**PERINATAL TRANSMISSION**

Was hepatitis B acquired as a result of perinatal transmission?  yes  no  unknown

If the case is less than 2 years old, please specify the mother's name. Mother's name \_\_\_\_\_

**IMMUNIZATION HISTORY**

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

yes  no  unknown Year last dose: \_\_\_\_\_ 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"/>

**POSSIBLE SOURCE(S) OF INFECTION**

The following questions are provided for the investigation of lifetime risk factors for HBV infection. Please ask if any of these situations ever applied to the case.

Patient interviewed?  yes  no     /    /      
date of interview

Other sources of information:

provider  medical record review  other \_\_\_\_\_ (specify)

**Check all that apply:**  no risk factor identified  patient could not be interviewed  patient previously reported in Oregon for acute hepatitis B

**Did any of the situations below EVER apply to the case?**

**yes no unk**

Was the patient ever on long-term hemodialysis?

Has the patient ever injected drugs not prescribed by a doctor (even if only once or a few times)?

Is the patient a man who has ever (even if only once) had sex with other men?

How many sex partners has the patient had (approximate lifetime)?

<20  20-50  >50

Was the patient ever incarcerated?

Last year incarcerated: \_\_\_\_\_

Was the patient ever treated for a sexually transmitted disease?

Was the patient ever a contact of a person who had hepatitis B?

If yes, type of contact:

Sexual  Household (non-sexual)

Needle  Other \_\_\_\_\_

Was the patient ever employed in a medical or dental field involving direct contact with human blood?

Provide details (by letter) for any risk factor(s) identified. Include names, dates, places, circumstances, etc., as applicable.



PATIENT'S NAME ▶

\_\_\_\_\_

**CASE-CONTACT AND PERINATAL CASE MANAGEMENT / FOLLOW-UP**

Case education provided?  yes  no  unknown

if yes, date \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient is currently pregnant:

due date \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the patient pregnant?  yes  no

Should she be retested prior to delivery?  yes  no

Trimester when screened  1st  2nd  3rd

Was an infant tracking file established?  yes  no

*If patient is pregnant, please complete the additional infant information on the hepatitis B perinatal case management form.*  
<http://oregon.gov/DHS/ph/acd/reporting/forms/hepbperi.pdf>

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.)

no other contacts identified

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended?
_____	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes by proxy <input type="checkbox"/> No	____/____/____ m d y <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Immune <input type="checkbox"/> Insignificant <input type="checkbox"/> NA exposure
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): ____/____/____ m d y
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended?
_____	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes by proxy <input type="checkbox"/> No	____/____/____ m d y <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Immune <input type="checkbox"/> Insignificant <input type="checkbox"/> NA exposure
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): ____/____/____ m d y
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended?
_____	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes by proxy <input type="checkbox"/> No	____/____/____ m d y <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Immune <input type="checkbox"/> Insignificant <input type="checkbox"/> NA exposure
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): ____/____/____ m d y
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Notes

**ADMINISTRATION**

Chronic Hepatitis B April 2009

Case report sent to OHS on \_\_\_\_/\_\_\_\_/\_\_\_\_

Completed by \_\_\_\_\_ Date Completed \_\_\_\_\_ Phone \_\_\_\_\_ Investigation sent to OHS on \_\_\_\_\_

PATIENT'S NAME

[Empty box for patient name]

**ADDITIONAL CONTACTS**

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended? ____/____/____
_____	____	_____	____/____/____	<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
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): ____/____/____
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended? ____/____/____
_____	____	_____	____/____/____	<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
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): ____/____/____
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended? ____/____/____
_____	____	_____	____/____/____	<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
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): ____/____/____
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended? ____/____/____
_____	____	_____	____/____/____	<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
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): ____/____/____
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended? ____/____/____
_____	____	_____	____/____/____	<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
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): ____/____/____
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended? ____/____/____
_____	____	_____	____/____/____	<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
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): ____/____/____
Tested for HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

Reproduce this page as needed for additional contacts.