Acute Hepatitis B

COUNTY

FOR STATE USE ONLY #

___/___/___ case report

___/___/___ interstate

☐ confirmed ☐ 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 ☐ Phone call ☐ Fax

☐ ICP ☐ Physician ☐ _____

Name _____

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

Primary M.D. _____ (if different)

OK to talk to patient? ☐

Phone _____

DEMOGRAPHICS

SEX
☐ female ☐ male

DATE OF BIRTH ____/____/____ m d y

or, if unknown, AGE _____

PLACE OF BIRTH
☐ USA
☐ other _____

HISPANIC
☐ yes ☐ no ☐ unknown

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

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	☐	☐	☐	☐
RIBA	☐	☐	☐	☐
HCV RNA (PCR)	☐	☐	☐	☐

Anti-HCV signal-to-cutoff ratio

_____

HCV genotype _____

Other _____

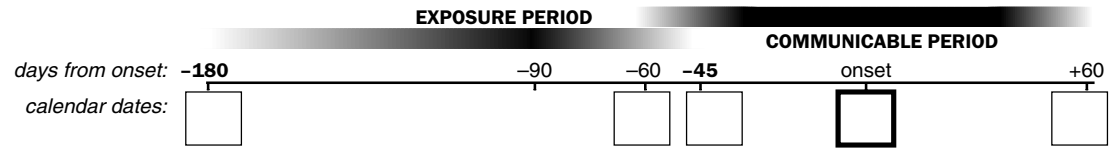
_____

	Upper limit normal	Date of test m/d/y
	(list reference value from lab slips)	
ALT (SGPT)	_____	___/___/____
AST (SGOT)	_____	___/___/____
Bilirubin	_____	___/___/____
other tests (specify)		
_____	_____	___/___/____
_____	_____	___/___/____
_____	_____	___/___/____

PATIENT'S NAME ▸ _____

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
_____	___/___/___	_____	☐ ☐
_____	___/___/___	_____	☐ ☐
_____	___/___/___	_____	☐ ☐

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

☐ yes ☐ no ☐ unknown

If yes, was serum anti-HBs ≥10mIU/ml?

☐ yes ☐ no ☐ unknown

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

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Interviewed? ☐ yes ☐ no Date Interviewed: _____

☐ Other sources of information: ☐ provider ☐ medical record review ☐ other _____

Check all that apply: ☐ no risk factor identified

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

yes no

☐ ☐ organ transplant/artificial insemination

☐ ☐ IG recipient (any kind: IVIG, TIG, HBIG, etc.)

☐ ☐ hemodialysis patient

☐ ☐ needlestick or similar injury

☐ ☐ had other exposure to someone else's blood

(specify) _____

☐ ☐ transfusion/other blood product recipient

if yes, date (m/d/y) ____/ ____ /____

☐ ☐ receive any infusions or injections in the outpatient setting

☐ ☐ dental work or oral surgery

☐ ☐ hospitalized

☐ ☐ other surgery

☐ ☐ employed in medical/dental field involving direct contact with human blood

if yes, frequency of direct blood contact

☐ frequent (several times weekly)

☐ infrequent

☐ ☐ employed as public safety worker (fire, police, corrections) having direct contact with human blood)

if yes, frequency of direct blood contact

☐ frequent (several times weekly)

☐ infrequent

yes no

☐ ☐ tattooing

if yes, where was it done?

☐ commercial parlor/shop

☐ correctional facility

☐ self

☐ _____

☐ ☐ body piercing (other than ear)

if yes, where was it done?

☐ commercial parlor/shop

☐ correctional facility

☐ self

☐ _____

☐ ☐ resident of long-term care facility

☐ ☐ incarcerated for more than 24 hours

if yes, in what type of facility

☐ prison

☐ jail

☐ juvenile facility

☐ ☐ diabetes

if yes, year of diagnosis _____

if yes, use a blood glucose monitor? ☐ yes ☐ no

if yes, share a glucose monitor? ☐ yes ☐ no

if yes, inject insulin? ☐ yes ☐ no

if yes, share syringes or needles? ☐ yes ☐ no

yes no

☐ ☐ any sexual contact

if yes, number of male sexual partners

☐ 0 ☐ 1 ☐ 2–5 ☐ >5 ☐ unknown

number of female sexual partners

☐ 0 ☐ 1 ☐ 2–5 ☐ >5 ☐ unknown

☐ ☐ uses street drugs but does not inject

☐ ☐ injects drugs not prescribed by doctor

if yes, primary drug injected (select only one):

☐ Methamphetamine/Speed

☐ Cocaine

☐ Speedball (cocaine & heroin together)

☐ Other _____

if yes, year of most recent drug use (if applicable) _____

During his/her lifetime, was patient *EVER*

☐ ☐ incarcerated more than 6 months

if yes, year of most recent incarceration _____

for how many months _____

☐ ☐ treated for a sexually transmitted disease

if yes, year of most recent treatment _____

PATIENT'S NAME ▸ ____________________

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.
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.) 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?
____________	______	____________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ yes by proxy ☐ no	☐ yes ☐ no ☐ immune ☐ insignificant exposure ☐ NA If yes, date recommended: ____/____/____ (m d y)

Prophylaxis given: ☐ Referred to HCP ☐ Refused ☐ HBIG ☐ Vaccine ☐ None Date prophylaxis given (if applicable): ____/____/____ (m d y)

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Notes

ADMINISTRATION

Case report sent to OHS on ____/____/____

Completed by ______________________ Date Completed ____________ Phone ______________ Investigation sent to OHS on ____/____/____