Chronic Hepatitis B

COUNTY

FOR STATE USE ONLY #

___/___/___ case report

___/___/___ interstate

☐ confirmed ☐ presumptive ☐ suspect

date investigation initiated__/___/___

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
☐ 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
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska native
☐ unknown
☐ refused to answer
☐ 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 ____/____/____ 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 _____

Has the patient previously tested HBsAg–positive?
☐ yes ☐ no ☐ unknown
if yes, when? ____/____/____ m d y

	Upper limit normal *(list reference value from lab slips)*	Date of test m/d/y
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 ▸

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
	__/__/__		☐	☐
	__/__/__		☐	☐
	__/__/__		☐	☐

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 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?	☐	☐	☐

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

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? ____/____/____ (m d y)
_______________	____	____________	____/____/____	☐ Yes ☐ No	☐ Yes ☐ Yes by proxy ☐ No ____/____/____	☐ Yes ☐ No ☐ Immune ☐ Insignificant exposure ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

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

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

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

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Notes

ADMINISTRATION

Case report sent to OHS on ____/____/____

Completed by ______________________________ Date Completed ___________ Phone ______________ Investigation sent to OHS on

PATIENT'S NAME ▸

ADDITIONAL CONTACTS

Name ________________ Age ____ Relation to Case _____________ Date Contacted ____/____/____ Located? ☐ Yes ☐ No Education Provided? ☐ Yes ☐ Yes by proxy ☐ No ____/____/____ Prophylaxis Recommended? ____/____/____ ☐ Yes ☐ No ☐ Immune ☐ Insignificant ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Name ________________ Age ____ Relation to Case _____________ Date Contacted ____/____/____ Located? ☐ Yes ☐ No Education Provided? ☐ Yes ☐ Yes by proxy ☐ No ____/____/____ Prophylaxis Recommended? ____/____/____ ☐ Yes ☐ No ☐ Immune ☐ Insignificant ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Name ________________ Age ____ Relation to Case _____________ Date Contacted ____/____/____ Located? ☐ Yes ☐ No Education Provided? ☐ Yes ☐ Yes by proxy ☐ No ____/____/____ Prophylaxis Recommended? ____/____/____ ☐ Yes ☐ No ☐ Immune ☐ Insignificant ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Name ________________ Age ____ Relation to Case _____________ Date Contacted ____/____/____ Located? ☐ Yes ☐ No Education Provided? ☐ Yes ☐ Yes by proxy ☐ No ____/____/____ Prophylaxis Recommended? ____/____/____ ☐ Yes ☐ No ☐ Immune ☐ Insignificant ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Name ________________ Age ____ Relation to Case _____________ Date Contacted ____/____/____ Located? ☐ Yes ☐ No Education Provided? ☐ Yes ☐ Yes by proxy ☐ No ____/____/____ Prophylaxis Recommended? ____/____/____ ☐ Yes ☐ No ☐ Immune ☐ Insignificant ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Name ________________ Age ____ Relation to Case _____________ Date Contacted ____/____/____ Located? ☐ Yes ☐ No Education Provided? ☐ Yes ☐ Yes by proxy ☐ No ____/____/____ Prophylaxis Recommended? ____/____/____ ☐ Yes ☐ No ☐ Immune ☐ Insignificant ☐ NA

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

Tested for HBV? ☐ Yes ☐ No ☐ Unknown

Reproduce this page as needed for additional contacts.