Washington State Department of HEALTH

Hepatitis B – Chronic, Interview

County

Case name (last, first) _____
Birth date ___/___/___ Alternate name _____
Phone _____ Email _____
Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work
Street address _____
City/State/Zip/County _____
Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No
Accountable County _____

ADMINISTRATIVE

☐ Hepatitis D co-infected
LHJ notification date ___/___/___ **Investigator**_____ **Investigation start date** ___/___/___

LHJ Classification ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ State case ☐ Contact ☐ Control ☐ Exposure ☐ Not classified

Investigation status ☐ Investigation not started ☐ In progress ☐ Complete ☐ Complete - not reportable to DOH ☐ Unable to complete
Investigation complete date ___/___/___ **LHJ record complete date** ___/___/___ (enter at the end)
Outbreak related ☐ Yes ☐ No **LHJ Cluster Name** _____ **LHJ Cluster ID** _____

REPORT SOURCE(S)

Report source _____ Report date ___/___/___
Reporter name _____ Reporter organization _____
Reporter phone _____
Diagnosis at a state correctional facility ☐ Yes ☐ No ☐ Unk Diagnosis type ☐ Acute ☐ Chronic

DEMOGRAPHICS

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?
Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown
What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses).
Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American
☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Additional race information:
☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: _____

Country of birth: _____

What is your (your childs) preferred language? Check one:
☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: _____ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

EMPLOYMENT AND SCHOOL

Patient is employed ☐ Yes ☐ No ☐ Unk Occupation _____ Workplace Zip code_____
Patient is a student (including daycare) ☐ Yes ☐ No ☐ Unk School name_____ School zip code_____

COMMUNICATIONS

OK to talk to patient? ☐ Yes ☐ Later ☐ Never ☐ Unk

Contact attempted ☐ Yes ☐ No

Contact attempt type:

☐ Phone call to patient ☐ Phone call to medical provider ☐ Medical record search (electronic or hardcopy)
☐ Text to patient ☐ Letter to patient ☐ E-mail to patient ☐ Patient's social media
☐ Other contact attempt type _____

Contact attempt outcome:

☐ Unable to contact ☐ Contacted and interviewed ☐ Contacted and scheduled ☐ Successful medical record review
☐ Left message ☐ Pending response ☐ Reinterviewed

If contact attempted, fill in date and interviewer.

Date ___/___/___ Interviewer _____ Interviewer's jurisdiction _____

Was patient acute, chronic or perinatal at the time of contact attempt? ☐ Acute ☐ Chronic ☐ Perinatal ☐ Unknown

Alternate contact ☐ Friend ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other (describe) _____
Contact name _____ Contact phone _____

COMMUNICATIONS: OPTIONAL LHJ USE - DATA ENTRY IN WDRS IS OPTIONAL FOR THIS SECTION

Multiple entries for different dates/types of contacts are possible for this section.

Information source:

☐ Provider/medical facility Provider/facility name _____
☐ Informant ☐ Internal
☐ Other local health jurisdiction Jurisdiction _____
☐ Other state health department State _____
☐ Other

Notes (free text, for each entry) Date ___/___/___ (for each entry) Time_____

CLINICAL EVALUATION

Chronic B diagnosis date ___/___/___
Age at diagnosis (patient reported) _____ years
Reason(s) for initial screening (select all the apply):

☐ Prenatal screening ☐ Follow-up testing for previous marker of viral hepatitis
☐ Blood/organ donor screening ☐ Elevated liver enzymes
☐ **Symptoms of acute hepatitis (vomiting, diarrhea, abdominal pain, anorexia, nausea or fever)**
☐ Asymptomatic with risk factors ☐ Other _____

Setting of initial screening:

☐ Primary care clinic ☐ ID/GI/liver clinic ☐ OB/GYN clinic ☐ Emergency room/urgent care
☐ Hospital ☐ Rehab facility ☐ Syringe exchange ☐ Jail/prison ☐ Non-clinical community site
☐ Other _____

Vaccination History

Washington Immunization Information System (WA IIS) number _____
Documented immunity to hepatitis A (due to either vaccination or previous infection)

☐ Yes – vaccination ☐ Yes – previous infection ☐ No ☐ Unk

Number of doses of HAV vaccine in past _____

Comorbidities

Y	N	Unk		
☐	☐	☐	**Diabetes**	diagnosis date ___/___/___
☐	☐	☐	Cirrhosis	diagnosis date ___/___/___
☐	☐	☐	Ever diagnosed with liver cancer	diagnosis date ___/___/___
☐	☐	☐	Liver transplant	diagnosis date ___/___/___

Hepatitis B-Chronic required variables are in **bold.** Answers are: Yes, No, Unknown to case

Y N Unk

☐ ☐ ☐ **Renal dialysis** diagnosis date ___/___/___

☐ ☐ ☐ Chronic kidney disease diagnosis date ___/___/___

☐ ☐ ☐ Patient ever tested for HCV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐Other

☐ ☐ ☐ Patient ever tested for HIV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐Other

Pregnancy

Y N Unk

☐ ☐ ☐ **Pregnant (*If No/Unk, skip to Clinical)***

Date the individual was assessed for pregnancy ___/___/___

Estimated delivery date ___/___/___ OB name _____

OB phone _____

Subtype at time of this pregnancy ☐ Acute ☐ Chronic ☐ Unk

☐ ☐ ☐ **Reported to Perinatal Hepatitis B Prevention Program (PHBPP)**

Perinatal Hepatitis B Prevention Program (PHBPP) Case ID _____

☐ ☐ ☐ Complications during pregnancy (specify) _____

Enter information after delivery:

Infant name (first, last) _____ WAIIS number _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other ☐ Unk

Delivery facility _____

Delivery provider _____

Where born ☐ In Washington – county _____ ☐ Other state _____

☐ Not in US - country _____ ☐ Unk

Infant's street address _____

City/State/Zip/County _____

Hospitalization and Death

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____

Admit date ___/___/___ Discharge date ___/___/___ Length of stay _____ days

If deceased, please change the vital status and update date of death on the Edit Person screen

Vital Status ☐ Alive ☐ Dead Death date ___/___/___

Cause of death ☐ Hepatitis related ☐ Hep C related ☐ Hep D related ☐ Other _____

Laboratory Diagnostics (Positive, Negative, Not tested, Indeterminate)

Enter all laboratory results in the Investigation Template/Lab Tab

P N NT I

☐ ☐ ☐ ☐ **Hepatitis B surface antigen (HBsAg)**

Specimen collection date ___/___/___ Specimen accession # _____

Test laboratory _____ Test provider/facility _____

☐ ☐ ☐ ☐ **Hepatitis B e antigen (HBeAg)**

Specimen collection date ___/___/___ Specimen accession # _____

Test laboratory _____ Test provider/facility _____

☐ ☐ ☐ ☐ **IgM antibody to hepatitis B core antigen (IgM anti-HBc)**

Specimen collection date ___/___/___ Specimen accession # _____

Test laboratory _____ Test provider/facility _____

HBV DNA quantitative _____ Quantitative units ☐ I.U. ☐ I.U., log ☐ DNA copies ☐ DNA copies, log

☐ ☐ ☐ ☐ Qualitative interpretation of quantitative result

Specimen collection date ___/___/___ Specimen accession # _____

Test laboratory _____ Test provider/facility _____

☐ ☐ ☐ ☐ **HBV DNA qualitative**

Specimen collection date ___/___/___ Specimen accession # _____

Test laboratory _____ Test provider/facility _____

☐ ☐ ☐ ☐ **HBV genotype** _____

Specimen collection date ___/___/___ Specimen accession # _____

Refer to Hepatitis D Guideline when reporting hepatitis D.

Liver Enzyme Tests

☐ ALT (SGPT) Specimen collection date ___/___/___ Actual value _____

EXPOSURES (If not otherwise specified report exposure information over the lifetime)

Chronic Exposure Information

Y N Unk

☐ ☐ ☐ Received clotting factor concentrates
☐ ☐ ☐ Received blood products
☐ ☐ ☐ Received solid organ transplant
☐ ☐ ☐ Other organ or tissue transplant recipient
☐ ☐ ☐ **Long term hemodialysis**
☐ ☐ ☐ **Employed in job with potential for exposure to human blood or body fluids**
Job type ☐ Medical ☐ Dental ☐ Public safety (e.g., law enforcement/firefighter) ☐ Tattoo/piercing
☐ Other _____
☐ ☐ ☐ Accidental stick or puncture with sharps contaminated with blood or body fluid
☐ ☐ ☐ History of occupational needle stick or splash
☐ ☐ ☐ Ever had a finger stick/prick blood sugar test
☐ ☐ ☐ Ear or body piercing
☐ ☐ ☐ Tattoo recipient
☐ ☐ ☐ Ever received acupuncture
☐ ☐ ☐ History of incarceration
☐ ☐ ☐ Birth mother has history of hepatitis B infection
☐ ☐ ☐ **Born outside US** **Country** _____ Number of years in the US _____
☐ ☐ ☐ Contact with confirmed or suspected hepatitis B case (acute or chronic)
Type of contact ☐ Household (non-sexual) ☐ Injection drug user ☐ Multiple contact types ☐ Sexual
☐ Other _____
Approximate number of lifetime sex partners _____
Gender of sex partners ☐ Male ☐ Female ☐ Transgender
☐ ☐ ☐ Received treatment for an STD
☐ ☐ ☐ **Ever injected drugs not prescribed by doctor, even if only once or a few times**
Type ☐ Heroin (includes Diacetylmorphine) ☐ Cocaine ☐ Amphetamine ☐ Methamphetamine ☐ MDMA
☐ Ketamine ☐ PCP ☐ Anabolic steroids ☐ Opioids (prescription or non-prescription)
☐ Unknown ☐ Other _____

Exposure Summary

Most likely exposure

☐ Acupuncture ☐ Blood product ☐ Body piercing (except ears) ☐ Chronic hemodialysis ☐ Close contact
☐ Clotting factor ☐ Incarceration ☐ Injection drug use ☐ In job with potential blood or body fluid exposure
☐ New or risk sexual partner ☐ Organ transplant ☐ Perinatal transmission ☐ Tattoo ☐ Multiple risk factors
☐ Unk ☐ Other _____

☐ **No risk factors or exposures could be identified**

Where did exposure probably occur ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk

Exposure location details (optional)

PUBLIC HEALTH ISSUES AND ACTIONS

Public Health Issues

Y	N	Unk	
☐	☐	☐	Patient aware of hepatitis support agencies (e.g., Hepatitis Education Project)
☐	☐	☐	Recent blood products, organs or tissue (Including ova or semen) donation

Public Health Actions

Y	N	Unk	
☐	☐	☐	Counseled on importance of regular healthcare to monitor liver health
☐	☐	☐	Counseled on avoidance of liver toxins (e.g., alcohol)
☐	☐	☐	Recommend hepatitis A vaccination
☐	☐	☐	Counseled on measure to avoid transmission
☐	☐	☐	Counseled to not donate blood products, organs or tissues
☐	☐	☐	**Notified blood or tissue bank (if recent donation)**
☐	☐	☐	Counseled about transmission risk to baby if pregnant
☐	☐	☐	**Referred to Perinatal Hepatitis B Prevention Program (PHBPP)**
☐	☐	☐	Reinforced use of universal precautions, if health care worker
☐	☐	☐	Counseled on harm reduction and places to access clean syringes, if current IDU
☐	☐	☐	Provided contact information for hepatitis support agencies
☐	☐	☐	Provided patient education materials about HBV
☐	☐	☐	Provided options for access to health care
☐	☐	☐	Provided information on alcohol/substance abuse treatment
☐	☐	☐	Other public health action _____

Public Health Actions (Continued)

Y	N	Unk	
☐	☐	☐	Counseled on harm reduction and places to access clean syringes, if current IDU
☐	☐	☐	Provided contact information for hepatitis support agencies
☐	☐	☐	Provided patient education materials about HBV
☐	☐	☐	Provided options for access to health care
☐	☐	☐	Provided information on alcohol/substance abuse treatment
☐	☐	☐	Other public health action _____

Evaluated Contacts

Y	N	Unk	
☐	☐	☐	Evaluated contacts Number of contacts evaluated _____
☐	☐	☐	Recommended prophylaxis of contacts Number recommended prophylaxis _____
☐	☐	☐	Recommended vaccination of contacts Number recommended vaccination _____

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