



Hepatitis B, acute

County _____

LHJ Use ID _____

Reported to DOH Date ____/____/____

LHJ Classification Confirmed
 Probable

By: Lab Clinical

Epi Link: _____

Outbreak-related

LHJ Cluster# _____

LHJ Cluster Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____

Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

OK to talk to case? Yes No DK Date of interview ____/____/____

PATIENT INFORMATION

Name (last, first) _____

Address _____ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact Parent/guardian Spouse Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender F M Other Unk

Ethnicity Hispanic or Latino

Not Hispanic or Latino Unk

Race (check all that apply)

Amer Ind/AK Native Asian

Native HI/other PI Black/Afr Amer

White Other Unk

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y N DK NA

Discrete onset of symptoms

Pale stool, dark urine (jaundice)

Onset date ____/____/____

Abdominal cramps or pain

Nausea

Vomiting

Loss of appetite (anorexia)

Fatigue

Predisposing Conditions

Y N DK NA

Pregnant

Estimated delivery date ____/____/____

OB name, address, phone: _____

History of viral hepatitis, specify type:

Hepatitis A Y N DK NA

Hepatitis B

Chronic hepatitis B infection

(HBsAg positive > 6 months)

Hepatitis C

Hepatitis D

Other viral hepatitis

Hepatitis of unknown type

Clinical Findings

Y N DK NA

Complications, specify: _____

Hospitalization

Y N DK NA

Hospitalized at least overnight for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

Died from illness Death date ____/____/____

Autopsy Place of death _____

Vaccinations

Y N DK NA

Received any doses of hepatitis B vaccine

Year of last HBV vaccine dose: _____

Number of doses of HBV vaccine in past: _____

Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ____/____/____

Source _____

P N I O NT

Hepatitis B core antigen IgM (anti-HBc)

HBsAg

Elevated serum aminotransferase (ALT>100)

In prior 6 months negative HBsAg, HBeAg, or HBV NAT (including, genotype)

INFECTION TIMELINE

Enter jaundice onset date in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset: -180 -45

Calendar dates:

o
n
s
e
t

Contagious period* many weeks prior, _____ weeks to years after, onset

* Lifelong if chronic infection

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Destinations/Dates: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with confirmed HBV case (acute or chronic) <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Casual contact <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jail or prison stay</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living Type: <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Long term care <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetic who lives in congregate living situation (school, assisted living facility, skilled nursing home, group home)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Surgery, other medical procedures, hospitalized</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemodialysis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IV or injection as outpatient</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood transfusion or blood products (e.g. IG, factor concentrates) Product: _____ Date of receipt: __/__/__</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Organ or tissue transplant recipient, date: __/__/__</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental work or oral surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in job with potential for exposure to human blood or body fluids, Job type: <input type="checkbox"/> Public safety <input type="checkbox"/> Health care (e.g. medical, dental, laundry) <input type="checkbox"/> Tattoo or piercing <input type="checkbox"/> Other Frequency of direct blood or body fluid exposure <input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Accidental stick or puncture with a sharps contaminated with blood or body fluids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Had contact with someone else's blood</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Body piercing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tattooing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shared razor, toothbrushes or nail care items</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-injection street drug use</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Injection street drug use, type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Household or sexual contact from endemic country, specify country: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any type of sexual contact with others during exposure period # female sexual partners: _____ # male sexual partners: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Accidental non-intact skin or mucous membrane exposure to blood</p> <p>How was this person likely exposed to the disease:</p> <p><input type="checkbox"/> Sexual contact <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Medical/dental procedure <input type="checkbox"/> Nonsexual close contact <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Multiple risk factors</p> <p>Where did exposure probably occur?</p> <p><input type="checkbox"/> U.S. but not WA (State: _____)</p> <p><input type="checkbox"/> In WA (County: _____)</p> <p><input type="checkbox"/> Not in U.S. (Country/Region: _____)</p> <p><input type="checkbox"/> Unknown</p> <p>Exposure details: _____</p> <p><input type="checkbox"/> No risk factors or exposures could be identified <input type="checkbox"/> Patient could not be interviewed</p>
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PUBLIC HEALTH ISSUES

Y N DK NA

Employed as health care worker, if yes: Employed in a job with human blood exposure: Several times a week Infrequently No Unknown

Patient in a dialysis or kidney transplant unit

Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: __/__/__
Agency and location: _____
Specify type of donation: _____

Failure of vaccine or postexposure prophylaxis

PUBLIC HEALTH ACTIONS

Notify blood or tissue bank

Prophylaxis of appropriate contacts recommended
Number recommended prophylaxis: _____
Number receiving prophylaxis: _____
Number completing prophylaxis: _____

Counseled patient regarding retesting in 3-6 months

If case is health care worker performing invasive procedures, advise strict adherence to recommended infection control practices (especially if HBe Ag positive)

Retesting during pregnancy recommended

Mom counseled about pregnancy risks

Investigate vaccine and postexposure prophylaxis failure

Other, specify: _____

Investigator _____ Phone/email: _____ Investigation complete date __/__/__

Local health jurisdiction _____ Record complete date __/__/__