



Hepatitis B, perinatal

County _____

LHJ Use ID _____

Reported to DOH Date ___/___/___

LHJ Classification Confirmed

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: ___/___/___ (diagnosis date if asymptomatic) Derived Diagnosis date: ___/___/___ Illness duration: ___ days

Signs and Symptoms

Y N DK NA

- Discrete onset of symptoms
- Diarrhea Maximum # of stools in 24 hours: _____
- Pale stool, dark urine (jaundice)
Onset date ___/___/___
- Vomiting

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 HBIG
Date received: ___/___/___
Timing of HBIG: Unknown
 0-12 hrs after birth 13-24 hrs after birth
 1-7 days after birth >7 days after birth

Y N DK NA

- Received hepatitis B containing vaccine
Number of doses: _____
- Dose 1 Type: _____ Date received: ___/___/___
- Dose 2 Type: _____ Date received: ___/___/___
- Dose 3 Type: _____ Date received: ___/___/___
- Dose 4 Type: _____ Date received: ___/___/___
- Dose 5 Type: _____ Date received: ___/___/___
- Dose 6 Type: _____ Date received: ___/___/___

Laboratory

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

(Testing recommend 3-6 months following completion of vaccine series)

Specimen Source _____

P N I O NT

HBsAg Collection date: ___/___/___

HBeAg Collection date: ___/___/___

Nucleic acid test for HBV-DNA
Collection date: ___/___/___

Qualitative _____

Quantitative _____

Genotype (if known) _____

INFECTION TIMELINE

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

Days from onset:	Exposure period	o n s e t	Contagious period
	birth		birth
Calendar dates:			

EXPOSURE (Refer to dates above)

- Y N DK NA
- Travel out of the state, out of the country, or outside of usual routine
Out of: County State Country
Destinations/Dates: _____
 - Born inside US**
 - Birth mother born outside of US
Country: _____
 - Birth mother race or ethnicity known
Race of mother:
 Amer Ind / Alaska Native Asian
 Black Native Hawaiian or Pacific Islander
 White Unknown
 Other: _____
 - Ethnicity of mother:
 Hispanic
 Non-hispanic
 Other/unknown
 - Birth mother confirmed HBsAg positive prior to or at time of delivery**
 - Birth mother confirmed HBsAg positive after delivery**

- Where did exposure probably occur?**
- U.S. but not WA (State: _____)
 - In WA (County: _____)
 - Not in U.S. (Country/Region: _____)
 - Unknown
- Exposure details:** _____
- No risk factors or exposures could be identified**
 - Patient could not be interviewed**

PUBLIC HEALTH ISSUES

PUBLIC HEALTH ACTIONS

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ___/___/___

Local health jurisdiction _____

Record complete date ___/___/___