



Hepatitis B - Acute

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 child's) 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 SCHOOLPatient 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 UnkContact 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 UnknownAlternate contact Friend Parent/Guardian Spouse/Partner Other (describe) _____

Contact name _____ Contact phone _____

CLINICAL EVALUATIONIllness duration _____ days **Symptom onset date** ___/___/___ Derived Acute diagnosis date ___/___/___**Y N Unk** **Discrete onset of symptoms** **Acute symptoms consistent with hepatitis** (such as jaundice, vomiting, diarrhea, abdominal cramps, loss of appetite, fatigue, fever)

If diarrhea, onset date ___/___/___

 Pale stool, dark urine, yellowing of skin or eyes (jaundice) OR bilirubin \geq 3.0 mg/dl Onset date ___/___/___**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 HBV vaccine in past _____

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) _____ WAIS 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 _____

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

Enter all laboratory results in the Investigation Template/Lab Tab

Negative HBsAg within the prior six month Yes No Unk

P N NT I

Hepatitis B surface antigen (HBsAg)

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 _____

Hepatitis B e antigen (HBeAg)

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 # _____

Test laboratory _____ Test provider/facility _____

HDV antibody (anti-HDV)

Specimen collection date ___/___/___

Specimen accession # _____

Test laboratory _____ Test provider/facility _____

HDV antigen

Specimen collection date ___/___/___

Specimen accession # _____

Test laboratory _____ Test provider/facility _____

HDV RNA

Specimen collection date ___/___/___

Specimen accession # _____

Test laboratory _____ Test provider/facility _____

Refer to Hepatitis D Guideline when reporting hepatitis D.

Liver Enzyme Tests

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

AST (SGOT) Specimen collection date ___/___/___ Actual value _____

Alanine Aminotransferase (ALT) >100 IU/L Yes No Unk

Hospitalization and Death

Y N Unk

Hospitalized at least overnight for this illness Hospital facility name _____

Hospital record number _____

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 ___/___/___

Source used to verify vital status Death records Medical records Other _____

Cause of death Hepatitis related Other

EXPOSURES (Ask about exposures 45-180 days before symptom onset)

Travel	Setting 1	Setting 2	Setting 3
Travel out of	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name			
Start and end dates	____/____/____ to ____/____/____	____/____/____ to ____/____/____	____/____/____ to ____/____/____

Y N Unk

- Case knows anyone with similar symptoms
 - Contact with a confirmed or suspected hepatitis B case (acute or chronic) (*multiple entries are possible*)
 Type of contact Household Sexual Birth Needle use Casual contact Other _____
 - Household or sexual contact from endemic country Country _____
 - Congregate living
 Type Barracks Corrections Group home Long term care School Shelter
 Other _____
 Type of corrections Jail Juvenile facility Prison
 Incarcerated longer than 24 hours Yes No Unknown
 - Diabetic who lives in congregate situation (school, assisted living facility, skilled nursing home, group home)
 - Any suspect medical or dental exposure** Describe _____
 - Surgery, including outpatient), other medical procedures, hospitalized during exposure period**
 Describe _____
 - Surgery (including outpatient, other than oral surgery)
 - Other medical procedures
 - Hospitalized during exposure period
 - Hemodialysis**
 - IV or injection as outpatient/IV infusion or injection in outpatient setting**
 - Transfusion, blood product or transplant** Date ____/____/____ Product Blood products Organs Tissue
 - Dental work or oral surgery**
 - 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 _____
 Frequency of direct blood or body fluids exposure
 Frequent (several times a week) Infrequent Unk
 - Other exposure to someone else's blood (including first aid)
 - Accidental stick or puncture with sharps contaminated with blood or body fluid
 - Ear or body piercing Body site Ears only Other _____
 Piercing was performed at Commercial parlor/shop Correctional facility Other _____
 Address/name _____
 - Received acupuncture
 - Tattoo recipient Body site _____
 Tattoo was performed at Commercial parlor/shop Correctional facility Other _____
 - Shared razor, toothbrushes, or nail care items
 - 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) Unk
 Other _____
 - Shared needles
 - Shared other injection equipment Specify _____
 - Ever used needle exchange services
 - Non-injection street drug use/use street drugs Specify drugs _____
 Route of administration Inhalation Oral Transdermal Other _____
 - Used drugs not prescribed by a doctor but route of administration is unknown
 Type Heroin (includes Diacetylmorphine) Cocaine Amphetamine Methamphetamine MDMA
 Ketamine PCP Anabolic steroids Opioids (prescription or non-prescription) Unk
 Other _____
 - Received treatment for an STD Year of most recent STD treatment _____
- Number of sex partners (during exposure period)
 Female _____
 Male _____

Y N Unk

- Possible hepatitis B reactivation
 Suspected reactivation cause (check all that apply)
 Cancer chemotherapy
 Immunosuppressive therapy (e.g., rituximab or other drugs which target B lymphocytes, high-dose steroids, anti-TNF agents)
 Patient with HIV infection who has discontinued HBV active antiviral drugs
 Undergoing solid organ or bone marrow transplantation
 Undergoing or recently had HCV treatment Other _____

Exposure Summary

- Most likely exposure** Illicit drugs Medical/dental procedure Nonsexual close contact Sexual contact
 Multiple risk factors Unk Other _____

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

Exposure location name _____ Exposure location address _____

Exposure location details (Notes)

- No risk factors or exposures could be identified

PUBLIC HEALTH ISSUES AND ACTIONS

Public Health Issues

Y N Unk

- Employed as a health care worker
 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 ___/___/___ Type of donation Blood products Organs Tissue (including ova or semen)
 Agency name _____ Location _____

Public Health Actions

Y N Unk

- Notified blood or tissue bank (if recent donation)
 Counseled on measure to avoid transmission
 Recommended hepatitis A vaccination if at risk and susceptible
 Notified healthcare facility if case had suspected exposure at facility
 Notified healthcare facility if case may have transmitted to others at facility
 Counseled patient regarding retesting in 3-6 months
 Counseled about transmission risk to baby if pregnant
 Investigate vaccine or post-exposure prophylaxis failure
 Failure of vaccine or post-exposure prophylaxis
 Other public health action _____
- Evaluated contacts Number of contacts evaluated _____
 Recommended prophylaxis of contacts Number recommended prophylaxis _____
 Recommended vaccination of contacts Number recommended vaccination _____

Contacts

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

	Contact 1	Contact 2	Contact 3	Contact 4
Date contact identified				
Contact first name				
Contact last name				
Birth date				
Age	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days
Sex	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Refused <input type="checkbox"/> Other <input type="checkbox"/> Unk	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Refused <input type="checkbox"/> Other <input type="checkbox"/> Unk	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Refused <input type="checkbox"/> Other <input type="checkbox"/> Unk	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Refused <input type="checkbox"/> Other <input type="checkbox"/> Unk
Phone				
Contact type (select one)	<input type="checkbox"/> Household (nonsexual) <input type="checkbox"/> Injection drug use <input type="checkbox"/> Sexual <input type="checkbox"/> Multiple <input type="checkbox"/> Other:	<input type="checkbox"/> Household (nonsexual) <input type="checkbox"/> Injection drug use <input type="checkbox"/> Sexual <input type="checkbox"/> Multiple <input type="checkbox"/> Other:	<input type="checkbox"/> Household (nonsexual) <input type="checkbox"/> Injection drug use <input type="checkbox"/> Sexual <input type="checkbox"/> Multiple <input type="checkbox"/> Other:	<input type="checkbox"/> Household (nonsexual) <input type="checkbox"/> Injection drug use <input type="checkbox"/> Sexual <input type="checkbox"/> Multiple <input type="checkbox"/> Other:
OK to talk with this contact:	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Later <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Later <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Later <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Later <input type="checkbox"/> Unk
Method of communication (select one)	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> In-person <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> In-person <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> In-person <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> In-person <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR

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

Contact interview date				
	Contact 1	Contact 2	Contact 3	Contact 4
Referred to PCP for evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Test result – susceptible	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Prophylaxis recommended	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Received prophylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Completed prophylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Prophylaxis type - HBIG	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Prophylaxis type – Hepatitis B vaccination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Optional LHJ ID				
Optional EMR number				
Optional Address				
Optional Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Optional Interpreter	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Optional Investigator				

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