Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Hepatitis B, acute

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
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
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ 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 ___/___/___
☐	☐	☐	☐	**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 ☐**Y** ☐**N** ☐**DK** ☐**NA**
Chronic hepatitis B infection (HBsAg positive > 6 months) ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis C ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis D ☐**Y** ☐**N** ☐**DK** ☐**NA**
Other viral hepatitis infection ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis of unknown type ☐**Y** ☐**N** ☐**DK** ☐**NA**

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Complications, specify: _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	**Autopsy**

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: _____ If 3 hepatitis B vaccine doses, titer of HBV antibody test 1-6 mo's from third dose: _____

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**IgM to core antigen (anti-HBc) positive**
☐	☐	☐	☐	**HBsAg positive**
☐	☐	☐	☐	**Serum aminotransferase [SGOT (AST), SGPT (ALT)] elevated above normal**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

Washington State Department of Health **Case Name:** _____

INFECTION TIMELINE

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

	Exposure period		***Contagious period****
Days from onset:	-180	-45	many weeks prior — onset — weeks to years after onset
Calendar dates:	☐	☐	☐

** Lifelong if chronic infection*

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: _____

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms

☐ ☐ ☐ ☐ Contact with confirmed or suspect HBV case
☐ Household ☐ Sexual
☐ Needle use ☐ Other: _____

☐ ☐ ☐ ☐ Birth mother-history of viral hepatitis

☐ ☐ ☐ ☐ Birth mother-HbsAg positive

☐ ☐ ☐ ☐ Birth mother has history of hepatitis C infection

☐ ☐ ☐ ☐ Congregate living Type:
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

☐ ☐ ☐ ☐ Hospitalized during exposure period

☐ ☐ ☐ ☐ Any medical or dental procedure:

☐ ☐ ☐ ☐ Hemodialysis

☐ ☐ ☐ ☐ IV or injection as outpatient

☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt: __/__/__

☐ ☐ ☐ ☐ Organ or tissue transplant recipient, date:__/__/__

☐ ☐ ☐ ☐ Dental work or oral surgery

☐ ☐ ☐ ☐ Non-oral surgery type: _____

☐ ☐ ☐ ☐ Acupuncture

☐ ☐ ☐ ☐ Employed in job with potential for exposure to human blood or body fluids, Job type:
☐ Public Safety ☐ Health care (e.g. medical, dental, laundry) ☐ Tattoo or piercing ☐ Other
Frequency of direct blood or body fluid exposure
☐ Frequent (several times weekly)
☐ Infrequent ☐ Unknown

Y N DK NA

☐ ☐ ☐ ☐ Accidental parenteral exposure to blood

☐ ☐ ☐ ☐ Accidental non-intact skin or mucous membrane exposure to blood

☐ ☐ ☐ ☐ Body piercing
☐ Home ☐ Commercial ☐ Prison ☐ Unk

☐ ☐ ☐ ☐ Tattooing
☐ Home ☐ Commercial ☐ Prison ☐ Unk

☐ ☐ ☐ ☐ Other body modification (e.g. scarification)

☐ ☐ ☐ ☐ Shared razor, toothbrushes or nail care items

☐ ☐ ☐ ☐ Non-injection street drug use
Shared equipment non-IDU ☐**Y** ☐**N** ☐**DK** ☐**NA**

☐ ☐ ☐ ☐ Injection street drug use, type: _____

☐ ☐ ☐ ☐ Shared injection equipment

☐ ☐ ☐ ☐ Born outside US

☐ ☐ ☐ ☐ Household or sexual contact from endemic country, specify country: _____

☐ ☐ ☐ ☐ Any type of sexual contact with others
lifetime total sexual partners: _____
female sexual partners: _____
male sexual partners: _____

☐ ☐ ☐ ☐ Ever diagnosed with an STD
Treated for STD ☐**Y** ☐**N** ☐**DK** ☐**NA**
Year of most recent treatment: _____

☐ ☐ ☐ ☐ Physical assault on exposed person involving blood or semen

☐ ☐ ☐ ☐ Other blood or body fluid exposure
Other exposure source: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____
Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

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: _____

☐ ☐ ☐ ☐ Outbreak related

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
☐ Other, specify: _____

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

Hepatitis B, acute: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered