

# Hepatitis B/C (acute or chronic)

Agency: \_\_\_\_\_

Investigator: \_\_\_\_\_

Phone number: \_\_\_\_\_

### FOR STATE USE ONLY

Status:  Confirmed  Probable  
 Suspect  Not a case  
Reviewer initials: \_\_\_\_\_  
Referred to another state: \_\_\_\_\_

## CASE

Last name: \_\_\_\_\_  
First and middle name: \_\_\_\_\_  
Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Address line: \_\_\_\_\_  
Zip: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ County: \_\_\_\_\_  
Long-term care resident:  Yes  No  Unknown  
Facility name: \_\_\_\_\_  
Facility phone: ( )- - Type: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_  
Gender:  Female  Male  Other \_\_\_\_\_  
Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Marital status:  Single  Parent with partner  Widowed  
 Married  Separated  
Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian  
Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown  
Parent/Guardian name: \_\_\_\_\_  
Parent/Guardian phone: ( )- - Type: \_\_\_\_\_

## EVENT

Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown  
Date of Death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Event exception:  Case could not be found  
 Case could not be interviewed  
 Case refused interview  
 Other – see notes  
Outbreak related:  Yes  No  Unknown  
Outbreak name: \_\_\_\_\_  
Exposure setting: \_\_\_\_\_  
Epi-linked:  Yes  No  Unknown  
Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown  
State: \_\_\_\_\_ Country: \_\_\_\_\_

Healthcare provider information

Last name: \_\_\_\_\_  
First name: \_\_\_\_\_  
Provider type:  ARNP  MD  PA  
 DO  NP  
Facility name: \_\_\_\_\_  
Address line 1: \_\_\_\_\_  
Address line 2: \_\_\_\_\_  
Zip code: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ County: \_\_\_\_\_  
Phone: ( )- - Type: \_\_\_\_\_

## LABORATORY FINDINGS (LIST ALL CURRENT AND PREVIOUS LAB RESULTS)

Laboratory: \_\_\_\_\_ Test type:  Hepatitis B surface antigen (HBsAg)  
*Hepatitis B/D*  Hepatitis B core IgM antibody (IgM HBc/IgM anti-HBc)  
Accession #: \_\_\_\_\_  Hepatitis B e antigen (HBeAg)  
 Hepatitis B core antibody total IgM/IgG antibody (HBc total/anti-HBc)  
Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Hepatitis B core IgG antibody (IgG HBc/IgG anti-HBc)  
 Hepatitis B DNA (HBV DNA)  
Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Hepatitis B surface antibody (anti-HBs)  
 Hepatitis D (anti-HDV)  
Specimen source: \_\_\_\_\_ Test type:  Hepatitis C antibody (anti-HCV)  Hepatitis C RNA (HCV RNA)  
*Hepatitis C*  Hepatitis C RIBA (HCV RIBA)  Hepatitis C Genotype  Hepatitis C IgG (EIA)  
 Hepatitis C DNA QL  
Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result type:  Preliminary  Final Result:  Positive  Negative

Laboratory: _____	Test type: <i>Hepatitis B/D</i>	<input type="checkbox"/> Hepatitis B surface antigen (HBsAg) <input type="checkbox"/> Hepatitis B core IgM antibody (IgM HBc/IgM anti-HBc) <input type="checkbox"/> Hepatitis B e antigen (HBeAg) <input type="checkbox"/> Hepatitis B core antibody total IgM/IgG antibody (HBc total/anti-HBc) <input type="checkbox"/> Hepatitis B core IgG antibody (IgG HBc/IgG anti-HBc) <input type="checkbox"/> Hepatitis B DNA (HBV DNA) <input type="checkbox"/> Hepatitis B surface antibody (anti-HBs) <input type="checkbox"/> Hepatitis D (anti-HDV)
Accession #: _____		<input type="checkbox"/> Hepatitis C antibody (anti-HCV) <input type="checkbox"/> Hepatitis C RNA (HCV RNA) <input type="checkbox"/> Hepatitis C RIBA (HCV RIBA) <input type="checkbox"/> Hepatitis C Genotype <input type="checkbox"/> Hepatitis C DNA QL <input type="checkbox"/> Hepatitis C IgG (EIA)
Collection date: ____/____/____		
Date received: ____/____/____		
Specimen source: _____	Test type: <i>Hepatitis C</i>	
Result date: ____/____/____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Laboratory: _____	Test type: <i>Hepatitis B/D</i>	<input type="checkbox"/> Hepatitis B surface antigen (HBsAg) <input type="checkbox"/> Hepatitis B core IgM antibody (IgM HBc/IgM anti-HBc) <input type="checkbox"/> Hepatitis B e antigen (HBeAg) <input type="checkbox"/> Hepatitis B core antibody total IgM/IgG antibody (HBc total/anti-HBc) <input type="checkbox"/> Hepatitis B core IgG antibody (IgG HBc/IgG anti-HBc) <input type="checkbox"/> Hepatitis B DNA (HBV DNA) <input type="checkbox"/> Hepatitis B surface antibody (anti-HBs) <input type="checkbox"/> Hepatitis D (anti-HDV)
Accession #: _____		<input type="checkbox"/> Hepatitis C antibody (anti-HCV) <input type="checkbox"/> Hepatitis C RNA (HCV RNA) <input type="checkbox"/> Hepatitis C RIBA (HCV RIBA) <input type="checkbox"/> Hepatitis C Genotype <input type="checkbox"/> Hepatitis C DNA QL <input type="checkbox"/> Hepatitis C IgG (EIA)
Collection date: ____/____/____		
Date received: ____/____/____		
Specimen source: _____	Test type: <i>Hepatitis C</i>	
Result date: ____/____/____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Laboratory: _____	Test type: <i>Hepatitis B/D</i>	<input type="checkbox"/> Hepatitis B surface antigen (HBsAg) <input type="checkbox"/> Hepatitis B core IgM antibody (IgM HBc/IgM anti-HBc) <input type="checkbox"/> Hepatitis B e antigen (HBeAg) <input type="checkbox"/> Hepatitis B core antibody total IgM/IgG antibody (HBc total/anti-HBc) <input type="checkbox"/> Hepatitis B core IgG antibody (IgG HBc/IgG anti-HBc) <input type="checkbox"/> Hepatitis B DNA (HBV DNA) <input type="checkbox"/> Hepatitis B surface antibody (anti-HBs) <input type="checkbox"/> Hepatitis D (anti-HDV)
Accession #: _____		<input type="checkbox"/> Hepatitis C antibody (anti-HCV) <input type="checkbox"/> Hepatitis C RNA (HCV RNA) <input type="checkbox"/> Hepatitis C RIBA (HCV RIBA) <input type="checkbox"/> Hepatitis C Genotype <input type="checkbox"/> Hepatitis C DNA QL <input type="checkbox"/> Hepatitis C IgG (EIA)
Collection date: ____/____/____		
Date received: ____/____/____		
Specimen source: _____	Test type: <i>Hepatitis C</i>	
Result date: ____/____/____	Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____/____/____	Phone: ( )- - Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Date of First Hep B Symptom Onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of First Hep C Symptom Onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the case ever had any of the following symptoms of hepatitis B or C (check all that apply)?  Yes  No

- Jaundice  Nausea  Upper right quadrant pain
 Dark urine  Vomiting  Clay-colored stools
 Fatigue  Anorexia  Other

Did the patient ever have elevated liver enzymes attributed to hepatitis B or C?  Yes  No  Unk

Why was this person tested for Hepatitis B/C (check all that apply)?

- Needle stick or other exposure  Elevated liver enzymes
 Symptoms of hepatitis B or C  Pregnancy screen
 Check for immunity due to vaccination  Follow-up on previous diagnosis
 Resolved infection  Screening for insurance
 Screening for blood/plasma donation  Other, please list reason \_\_\_\_\_

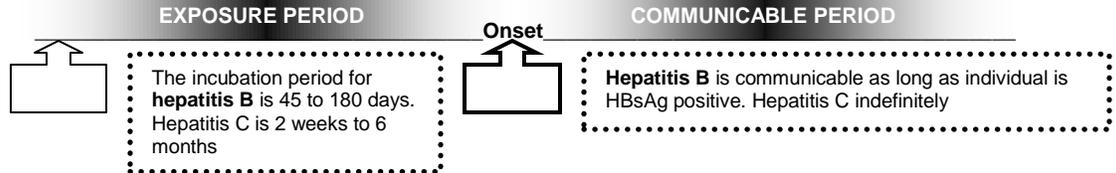
Does the case have symptoms now (last 180 days) or did they occur in the past?  Presently symptomatic  Past symptoms

ALT performed?  Yes  No  Unk
AST performed?  Yes  No  Unk

Result (in IU/l): Expected min (in IU/l): Expected max in IU/l:
Result (in IU/l): Expected min (in IU/l): Expected max in IU/l:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

CASE HISTORY

Was the case diagnosed with hepatitis B?  Yes  No  Unk
Year of diagnosis: \_\_\_\_\_
Treated for hep B:  Yes  No  Unk
Treatment successful:  Yes  No  Unk
Was the case diagnosed with hepatitis C?  Yes  No  Unk
Year of diagnosis: \_\_\_\_\_
Treated for hep C:  Yes  No  Unk
Treatment successful:  Yes  No  Unk
Case's mother born outside the U.S.?  Yes  No  Unk
If YES, what country: \_\_\_\_\_
Case born outside the U.S.?  Yes  No  Unk
If YES, what country: \_\_\_\_\_
Does the case speak English?  Yes  No  Unk
If No, what language: \_\_\_\_\_

Case ever had contact with a confirmed or suspected acute/chronic case of hep B or C?  Yes  No  Unk
If YES, type of contact:
 Sexual  Yes  No  Unk
 Household  Yes  No  Unk
 Blood to Mucous Membrane  Yes  No  Unk
 Needle sharing  Yes  No  Unk
 Other  Yes  No  Unk
Has the case ever received or been exposed to blood or blood products?  Yes  No  Unk
If YES, approximate years received or exposed: \_\_\_\_\_
Sexual orientation?  Men  Women  Both
Number of sexual partners in lifetime?  0  ≤10  >10

Has the case ever had an organ/tissue transplant?  Yes  No  Unk
Has case ever received a tattoo?  Yes  No  Unk
If YES, was it done in a commercial parlor/shop:  Yes  No  Unk
Name and location of parlor/shop: \_\_\_\_\_
Case ever used needles for injection of street drugs or steroids (even once)?  Yes  No  Unk
Has the case ever shared needles or works for injecting drugs (even once)?  Yes  No  Unk
Has the case ever snorted cocaine or other street drugs (even once)?  Yes  No  Unk
Is the case a military veteran?  Yes  No  Unk

Does the case currently serve in the military?  Yes  No  Unk
Is the case currently in prison?  Yes  No  Unk
If NO, have you ever been in prison?  Yes  No  Unk
If YES, then list dates to and from: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

In the 6 months prior to illness did the case...

Case ever had contact with a confirmed or suspected acute/chronic case of hep B or C?  Yes  No  Unk
If YES, type of contact:
 Sexual  Yes  No  Unk
 Household  Yes  No  Unk
 Blood to Mucous Membrane  Yes  No  Unk
 Needle sharing  Yes  No  Unk
 Other  Yes  No  Unk
Work in the:
Medical  Yes  No  Unk Dental  Yes  No  Unk
Other field involving contact with human blood or other body fluids  Yes  No  Unk
Degree of contact with blood:  Frequent  Infrequent  Unk

Received blood or blood products?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
If YES, list dates received: _____ / _____ / _____				
Receive dialysis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Used needles for injection of street drugs or steroids?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Had dental work or oral surgery?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Had surgery?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Acupuncture?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Body Piercing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Received a tattoo?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
If YES, was it done in a commercial parlor/shop? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
Name and location of parlor/shop: _____				
Have you ever had an accidental needle stick?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk

**VACCINATION HISTORY**

Has the patient ever received any doses of the hepatitis B vaccine?  Yes  No  Unknown

Date vaccinated: _____ / _____ / _____	Date vaccinated: _____ / _____ / _____	Date vaccinated: _____ / _____ / _____
Lot #: _____	Lot #: _____	Lot #: _____
Vaccine type: _____	Vaccine type: _____	Vaccine type: _____
Manufacturer: _____	Manufacturer: _____	Manufacturer: _____

Number of vaccinations: \_\_\_\_\_

Was antibody testing done within 1-6 months after last dose?

Yes  No  Unk If yes, was the antibody test:  Positive  Negative  Unk

Has the patient been vaccinated for hepatitis A?  Yes  No  Unknown

Date vaccinated: _____ / _____ / _____	Date vaccinated: _____ / _____ / _____
Lot #: _____	Lot #: _____
Vaccine type: _____	Vaccine type: _____
Manufacturer: _____	Manufacturer: _____

Number of vaccinations: \_\_\_\_\_

**CONTACTS**

Is the case pregnant?  Yes  No  Unknown

Anticipated delivering hospital: \_\_\_\_\_

Has the patient given birth in the last 6 months?  Yes  No  Unknown Hospital: \_\_\_\_\_

Trimester tested: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup>	Providers Last name: _____
Infant's Last name: _____	Providers First name: _____
Infants First name: _____	Provider type: <input type="checkbox"/> ARNP <input type="checkbox"/> DO <input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> PA
Infant alias: _____	Facility name: _____
DOB: _____ / _____ / _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Address: _____
Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Unk <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Asian	Zip code: _____ City: _____
	State: _____ County: _____
	Phone: ( )- - Type: _____

Infant serology tested:  Yes  No  Unk

Date: _____ / _____ / _____	Date: _____ / _____ / _____
HBsAg result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done	HBsAg result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done
Anti-HBs result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done	Anti-HBs result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done
Infant immune to hepatitis B: <input type="checkbox"/> Infant immune <input type="checkbox"/> Infant not immune	Infant immune to hepatitis B: <input type="checkbox"/> Infant immune <input type="checkbox"/> Infant not immune

