Washington State Department of Health

Hepatitis B - Acute

County

Case name (last, first) _____
Birth date ___/___/___ Sex ☐ F ☐ M ☐ Other 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

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 _____

DEMOGRAPHICS

Age (if DOB unknown) _____ years
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____
Country of birth _____
Primary language _____
Interpreter needed ☐ Yes ☐ No ☐ Unk
Employed ☐ Yes ☐ No ☐ Unk
Occupation _____
Employer/worksite _____ Work zip code _____
Student/Day care ☐ Yes ☐ No ☐ Unk
School/childcare_____
Grade _____ School zip code _____

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
Department of corrections number _____

COMMUNICATIONS

OK to talk to patient? ☐ Yes ☐ Later ☐ Never ☐ Unk

Interview performed ☐ Yes
If interview performed, fill in date and interviewer.
Date ___/___/___ Interviewer _____

Interview performed ☐ No
If interview not performed, select the reason.
Reason ☐ Lost to follow-up ☐ Refused ☐ Deceased
☐ Out of jurisdiction ☐ Language barrier
☐ Other _____

Alternate contact ☐ Friend ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other _____
Contact name _____
Contact phone _____

CLINICAL EVALUATION

Illness 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 ≥ 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 _____

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

Pregnancy (at time of report)

Y N Unk

☐ ☐ ☐ Pregnant (*If No/Unk, skip to Laboratory Diagnostics)*

☐ ☐ ☐ If Acute, Retesting during pregnancy recommended

Estimated delivery date ___/___/___ OB name _____

OB phone _____ OB address _____

☐ ☐ ☐ Reported to Perinatal Hepatitis B Prevention Program (PHBPP)

Enter information after delivery:

Infant name (first, last) _____ WAIIS number _____

Birth date ___/___/___ Sex ☐ F ☐ M ☐ Other ☐ Unk Delivery facility _____

Where born ☐ In Washington – county _____ ☐ Other state _____

☐ Not in US - country _____ ☐ Unk

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	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ 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

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

☐ ☐ ☐ If case is health care worker performing invasive procedures, advise strict adherence to recommended infection control practices

☐ ☐ ☐ 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	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days
Sex	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk
Phone				
Contact type (select **one**)	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexu al ☐ Multiple ☐ Other:	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple ☐ Other:	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple ☐ Other:	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple ☐ Other:
OK to talk with this contact:	☐Yes ☐Never ☐Later ☐Unk	☐Yes ☐Never ☐Later ☐Unk	☐Yes ☐Never ☐Later ☐Unk	☐Yes ☐Never ☐Later ☐Unk
Method of communication (select **one**)	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR
Contact interview date				

	Contact 1	**Contact 2**	**Contact 3**	**Contact 4**
Referred to PCP for evaluation	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Test result – susceptible	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Prophylaxis recommended	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Received prophylaxis	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Completed prophylaxis	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Prophylaxis type - HBIG	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Prophylaxis type – Hepatitis B vaccination	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional LHJ ID				
Optional EMR number				
Optional Address				
Optional Pregnant	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional Interpreter	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional Investigator				