Washington State Department of HEALTH

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 childs) 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 SCHOOL

Patient 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 ☐ Unk

Contact 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 ☐ Unknown

Alternate contact ☐ Friend ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other (describe) _____
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 _____

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) _____ WAIIS 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	☐ 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 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	☐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				