Washington State Department of Health

Hepatitis B – Chronic, Interview

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 case 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 _____
Work zip code _____
Student/Day care ☐ Yes ☐ No ☐ Unk
School/childcare_____
School zip code _____

REPORT SOURCE(S)

Report source _____
Report date ___/___/___
Reporter name _____
Reporter organization _____
Reporter phone _____

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 _____

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

Multiple entries for different dates/types of contacts are possible for this section.
Information source:
☐ Provider/medical facility Provider/facility name _____
☐ Informant ☐ Internal
☐ Other local health jurisdiction Jurisdiction _____
☐ Other state health department State _____
☐ Other
Notes (free text, for each entry) Date ___/___/___ (for each entry)

CLINICAL EVALUATION

Chronic B diagnosis date ___/___/___
Age at diagnosis (patient reported) _____ years
Hepatitis D diagnosis year _____
Reason(s) for initial screening (select all the apply):

☐ Prenatal screening ☐ Follow-up testing for previous marker of viral hepatitis
☐ Blood/organ donor screening ☐ Elevated liver enzymes
☐ **Symptoms of acute hepatitis (vomiting, diarrhea, abdominal pain, anorexia, nausea or fever)**
☐ Asymptomatic with risk factors ☐ Other _____

Setting of initial screening:

☐ Primary care clinic ☐ ID/GI/liver clinic ☐ OB/GYN clinic ☐ Emergency room/urgent care
☐ Hospital ☐ Rehab facility ☐ Syringe exchange ☐ Jail/prison ☐ Non-clinical community site
☐ Other _____

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 HAV vaccine in past _____

Comorbidities

Y N Unk

☐ ☐ ☐ **Diabetes** diagnosis date ___/___/___
☐ ☐ ☐ Cirrhosis diagnosis date ___/___/___
☐ ☐ ☐ Ever diagnosed with liver cancer diagnosis date ___/___/___
☐ ☐ ☐ Liver transplant diagnosis date ___/___/___
☐ ☐ ☐ **Renal dialysis** diagnosis date ___/___/___
☐ ☐ ☐ Chronic kidney disease diagnosis date ___/___/___
☐ ☐ ☐ Patient ever tested for HCV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other
☐ ☐ ☐ Patient ever tested for HIV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other

Pregnancy (at time of report)

Y N Unk

☐ ☐ ☐ **Pregnant (*If No/Unk, skip to Clinical)***
Estimated delivery date ___/___/___ OB name _____
OB phone _____ OB address _____
☐ ☐ ☐ **Reported to Perinatal Hepatitis B Prevention Program (PHBPP)**
☐ ☐ ☐ Complications during pregnancy _____

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

Hospitalization and Death

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____
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 ___/___/___
Cause of death ☐ Hepatitis related ☐ Hep C related ☐ Hep D related ☐ Other _____

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

Enter all laboratory results in the Investigation Template/Lab Tab

P N NT I

☐ ☐ ☐ ☐ **Hepatitis B surface antigen (HBsAg)**
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 _____

☐ ☐ ☐ ☐ **IgM antibody to hepatitis B core antigen (IgM anti-HBc)**
Specimen collection date ___/___/___ Specimen accession # _____
Test laboratory _____ Test provider/facility _____

P N NT I *(Positive, Negative, Not tested, Indeterminate)*

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 _____

EXPOSURES (If not otherwise specified report exposure information over the lifetime)

Chronic Exposure Information

Y N Unk
☐ ☐ ☐ Received clotting factor concentrates When ☐ Before 1987 ☐ 1987 or later
☐ ☐ ☐ Received blood products When ☐ Before 1992 ☐ 1992 or later
☐ ☐ ☐ Received solid organ transplant When ☐ Before 1992 ☐ 1992 or later
☐ ☐ ☐ Other organ or tissue transplant recipient Date ___/___/_____
☐ ☐ ☐ **Long term hemodialysis**
☐ ☐ ☐ **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 _____
☐ ☐ ☐ Accidental stick or puncture with sharps contaminated with blood or body fluid
☐ ☐ ☐ History of occupational needle stick or splash
☐ ☐ ☐ Ever had a finger stick/prick blood sugar test
☐ ☐ ☐ Ear or body piercing
☐ ☐ ☐ Tattoo recipient
☐ ☐ ☐ Ever received acupuncture
☐ ☐ ☐ History of incarceration
☐ ☐ ☐ Birth mother has history of hepatitis B infection
☐ ☐ ☐ **Born outside US Country** _____ Number of years in the US _____
☐ ☐ ☐ Contact with confirmed or suspected hepatitis B case (acute or chronic)
Type of contact ☐ Household (non-sexual) ☐ Injection drug user ☐ Multiple contact types ☐ Sexual
☐ Other _____
Approximate number of lifetime sex partners _____
Gender of sex partners ☐ Male ☐ Female ☐ Transgender
☐ ☐ ☐ Received treatment for an STD
☐ ☐ ☐ **Ever 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)
☐ Unknown ☐ Other _____
☐ ☐ ☐ Ever shared needles
☐ ☐ ☐ Ever shared other injection equipment Specify _____
☐ ☐ ☐ Ever used needle exchange services
☐ ☐ ☐ **Patient used injection drugs in the past 3 months**

Exposure Summary

Most likely exposure

☐ Acupuncture ☐ Blood product ☐ Body piercing (except ears) ☐ Chronic hemodialysis ☐ Close contact
☐ Clotting factor ☐ Incarceration ☐ Injection drug use ☐ In job with potential blood or body fluid exposure
☐ New or risk sexual partner ☐ Organ transplant ☐ Perinatal transmission ☐ Tattoo ☐ Multiple risk factors
☐ Unk ☐ Other _____

☐ **No risk factors or exposures could be identified**

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

Exposure location details (optional)

PUBLIC HEALTH ISSUES AND ACTIONS

Public Health Issues

Y	N	Unk	
☐	☐	☐	Patient aware of hepatitis support agencies (e.g., Hepatitis Education Project)
☐	☐	☐	Recent blood products, organs or tissue (Including ova or semen) donation

Public Health Actions

Y	N	Unk	
☐	☐	☐	Counseled on importance of regular healthcare to monitor liver health
☐	☐	☐	Counseled on avoidance of liver toxins (e.g., alcohol)
☐	☐	☐	Recommend hepatitis A vaccination
☐	☐	☐	Counseled on measure to avoid transmission
☐	☐	☐	Counseled to not donate blood products, organs or tissues
☐	☐	☐	**Notified blood or tissue bank (if recent donation)**
☐	☐	☐	Counseled about transmission risk to baby if pregnant
☐	☐	☐	**Referred to Perinatal Hepatitis B Prevention Program (PHBPP)**
☐	☐	☐	Reinforced use of universal precautions, if health care worker
☐	☐	☐	Counseled on harm reduction and places to access clean syringes, if current IDU
☐	☐	☐	Provided contact information for hepatitis support agencies
☐	☐	☐	Provided patient education materials about HBV
☐	☐	☐	Provided options for access to health care
☐	☐	☐	Provided information on alcohol/substance abuse treatment
☐	☐	☐	Other public health action _____

Evaluated Contacts

Y	N	Unk	
☐	☐	☐	Evaluated contacts Number of contacts evaluated _____
☐	☐	☐	Recommended prophylaxis of contacts Number recommended prophylaxis _____
☐	☐	☐	Recommended vaccination of contacts Number recommended vaccination _____