



Hepatitis B – Chronic, Interview

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 child's) 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 _____

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) Time _____

CLINICAL EVALUATION

Chronic B diagnosis date ___/___/___

Age at diagnosis (patient reported) _____ years

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 ___/___/___

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

Y N Unk

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

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) _____ WAIS 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 _____

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 _____

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 # _____

Refer to Hepatitis D Guideline when reporting hepatitis D.

Liver Enzyme Tests

ALT (SGPT) 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
- Received blood products
- Received solid organ transplant
- Other organ or tissue transplant recipient
- 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 _____

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 _____

Public Health Actions (Continued)

Y N Unk

- 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 _____

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