Washington State Department of Health

Hepatitis B - Perinatal

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)

DEMOGRAPHICS: Refers to Child ≤24 Months of Age

Age (if DOB unknown)_____ ☐ Years ☐ Months
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

Outbreak
Outbreak related ☐ Yes ☐ No
LHJ Cluster Name _____ LHJ Cluster ID _____

REPORT SOURCE(S)

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

COMMUNICATIONS

OK to talk to patient? (Refers to mother) ☐ 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

Maternal Information
Delivery hospital _____

Y	N	DK	NA	
☐	☐	☐	☐	**Birth mother confirmed HBsAg positive prior to or at time of delivery**
☐	☐	☐	☐	**Birth mother confirmed HBsAg positive after delivery**
☐	☐	☐	☐	**Birth mother confirmed Hepatitis B e antigen (HBeAg) positive**

Y	N	DK	NA	
☐	☐	☐	☐	Birth mother born outside of USA Country _____
☐	☐	☐	☐	Birth mother race or ethnicity known

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply) ☐ Amer Ind/AK Native ☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Onset and Diagnosis

Symptom onset date ___/___/___ *Enter date of testing as onset date*

Y N Unk

☐ ☐ ☐ Asymptomatic with risk factors (if asymptomatic, select 'Yes')

☐ ☐ ☐ Symptoms of acute hepatitis (vomiting, diarrhea, abdominal pain, anorexia, nausea, or fever)

Infant Vaccination History

Washington Immunization Information System (WA IIS) number _____

Y N Unk

☐ ☐ ☐ Received HBIG Date ___/___/___ Timing ☐ 0-12 hours after birth ☐ 13-24 hours after birth ☐ 1-7 days after birth ☐ >7 days after birth ☐ Unk

☐ ☐ ☐ Received hepatitis B containing vaccine Number of doses _____

Dose 1 Date ___/___/___ Vaccine type ☐ Single-antigen HBV Brand name ☐ Energix-B ☐ Recombivax HB ☐ HBV combination Brand name ☐ Comvax ☐ Pediarix

Lot number _____ Manufacturer _____

Administering provider _____

Information source ☐ WIIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Dose 2 Date ___/___/___ Vaccine type ☐ Single-antigen HBV Brand name ☐ Energix-B ☐ Recombivax HB ☐ HBV combination Brand name ☐ Comvax ☐ Pediarix

Lot number _____ Manufacturer _____

Administering provider _____

Information source ☐ WIIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Dose 3 Date ___/___/___ Vaccine type ☐ Single-antigen HBV Brand name ☐ Energix-B ☐ Recombivax HB ☐ HBV combination Brand name ☐ Comvax ☐ Pediarix

Lot number _____ Manufacturer _____

Administering provider _____

Information source ☐ WIIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Dose 4 Date ___/___/___ Vaccine type ☐ Single-antigen HBV Brand name ☐ Energix-B ☐ Recombivax HB ☐ HBV combination Brand name ☐ Comvax ☐ Pediarix

Lot number _____ Manufacturer _____

Administering provider _____

Information source ☐ WIIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Dose 5 Date ___/___/___ Vaccine type ☐ Single-antigen HBV Brand name ☐ Energix-B ☐ Recombivax HB ☐ HBV combination Brand name ☐ Comvax ☐ Pediarix

Lot number _____ Manufacturer _____

Administering provider _____

Information source ☐ WIIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Dose 6 Date ___/___/___ Vaccine type ☐ Single-antigen HBV Brand name ☐ Energix-B ☐ Recombivax HB ☐ HBV combination Brand name ☐ Comvax ☐ Pediarix

Lot number _____ Manufacturer _____

Administering provider _____

Information source ☐ WIIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Insurance

Insurance status date ___/___/___ Patients has insurance ☐ Yes ☐ No ☐ Unk

Type of insurance ☐ Medicare ☐ Medicaid ☐ VA/military ☐ Employer ☐ Individual ☐ Other _____

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

Death

If deceased, please change the vital status and update date of death on the Edit Person screen

Vital Status ☐ Death ☐ Alive

Death date ___/___/___

Source used to verify vital status ☐ Death records ☐ Medical records ☐ Other _____

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

Enter all laboratory results in the Investigation Template/Lab Tab.

(Positive, Negative, Not tested, Indeterminate)

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 # _____
Test laboratory _____ Test provider/facility _____

Liver Enzyme Tests

☐ ALT (SGPT) Specimen collection date ___/___/___ Actual value _____
☐ AST (SGOT) Specimen collection date ___/___/___ Actual value _____

PUBLIC HEALTH ISSUES AND ACTIONS

Y N Unk

☐ ☐ ☐ Failure of vaccine or post-exposure prophylaxis
☐ ☐ ☐ Counseled parents about importance of Hep A and Hep B vaccines
☐ ☐ ☐ Counseled parents on importance of regular healthcare to monitor liver health

NOTES