



Hepatitis B - Perinatal

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

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 _____

DEMOGRAPHICS: Refers to Child ≤24 Months of Age

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
 Country of birth (your child): _____
 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: _____
 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

COMMUNICATIONSOK to talk to patient? (Refers to guardian for infant.) Yes Later Never UnkContact 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 UnknownAlternate contact Friend Parent/Guardian Spouse/Partner Other (describe) _____

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 knownEthnicity Hispanic or Latino Not Hispanic or Latino UnkRace (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

Infant had symptoms of acute hepatitis? Yes No Unk

Perinatal diagnosis date ___/___/___

Infant Vaccination History

Washington Immunization Information System (WA IIS) number _____

Received HBIG? Yes No Unk

Date HBIG received ___/___/___

Timing of HBIG 0-12 hours after birth 13-24 hours after birth 1-7 days after birth >7 days after birth
 UnknownReceived hepatitis B containing vaccine? Yes No Unk

Number of doses _____

Date of vaccine administration #1 ___/___/___

Vaccine administered (type) Single antigen HBV HBV combination

Vaccine brand name _____

Vaccine lot number _____

Vaccine manufacturer _____

Administering provider _____

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

Date of vaccine administration #2 ___/___/___

Vaccine administered (type) Single antigen HBV HBV combination

Vaccine brand name _____

Vaccine lot number _____

Vaccine manufacturer _____

Administering provider _____

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

Date of vaccine administration #3 ___/___/___

Vaccine administered (type) Single antigen HBV HBV combination

Vaccine brand name _____

Vaccine lot number _____

Vaccine manufacturer _____

Administering provider _____

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

Insurance

Insurance status date ___/___/___

Death

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

Vital Status Dead 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

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.