Washington State Department of Health

Hepatitis B – Chronic, Surveillance

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 ID _____Cluster Name _____

DEMOGRAPHICS

Age _____ 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 _____

CLINICAL EVALUATION

Chronic B diagnosis date ___/___/___ Hepatitis D diagnosis year _____
Reason(s) for initial screening ☐ 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 _____

Pregnancy (at time of report)
Y N Unk
☐ ☐ ☐ **Pregnant** (*If No/Unk, skip to Death)*
Estimated delivery date ___/___/___ OB name _____
OB phone _____ OB address _____
☐ ☐ ☐ **Reported to Perinatal Hepatitis B Prevention Program (PHBPP)** if pregnant

Death
If deceased, please change the vital status and update date of death on the Edit Person screen
Vital Status ☐ Alive ☐ Dead
Death date ___/___/___

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

Chronic Exposure Information
Y N Unk
☐ ☐ ☐ **Long term hemodialysis**
☐ ☐ ☐ **Employed in job with potential for exposure to human blood or body fluids**
☐ ☐ ☐ **Born outside US Country** _____
☐ ☐ ☐ **Ever injected drugs** not prescribed by doctor, even if only once or a few times

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 # _____
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 _____