



Hepatitis B – Chronic, Surveillance

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 _____
 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 _____

CLINICAL EVALUATION

Chronic B diagnosis date ___/___/___ Hepatitis D diagnosis year _____ Age at diagnosis (patient reported) _____

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

Y N Unk

Pregnant (If No/Unk, skip to Death)

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) if pregnant

Perinatal Hepatitis B Prevention Program (PHBPP) Case ID _____

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 _____

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
- Possible hepatitis B reactivation

Suspected reactivation cause (check all that apply)

- Cancer chemotherapy
- Immunosuppressive therapy (e.g., rituximab or other drugs which target B lymphocytes, high-dose steroids, anti-TNF agents)
- Patient with HIV infection who has discontinued HBV active antiviral drugs
- Undergoing solid organ or bone marrow transplantation
- Undergoing or recently had HCV treatment 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 # _____
Test laboratory _____ Test provider/facility _____

HDV antibody (anti-HDV)
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.

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.