West Virginia Bureau for Public Health
Department of Health & Human Resources
Your Health Your Safety Our Purpose

Perinatal Hepatitis B

PATIENT DEMOGRAPHICS

Name: (last, first): _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
Phone (home): _____ **Phone(work/cell)**: _____
Alternate contact: ☐ *Parent/Guardian* ☐ *Spouse* ☐ *Other*
Name: _____ *Phone:* _____

Birth date: __ / __ / ____ **Age**: _____
Sex: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Native HI/Other PI ☐Am. Ind/AK Native ☐Asian ☐ Unk

INVESTIGATION SUMMARY

Investigation Start Date: __ /__ /____ Investigator: _____ Investigator phone: _____

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐ Laboratory ☐Hospital ☐ Private Provider ☐ Public Health Agency ☐Other – Specify _____
Reporter Name: _____ Reporter Phone: _____
Earliest date reported to LHD: __ /__ /____ **Earliest date reported to State: __ /__ /____**

CLINICAL

Primary HCP Name: _____ Primary HCP Phone: _____

Y N U
☐ ☐ ☐ Patient hospitalized for this illness
If yes, hospital name:_____
Patient Chart #_____(if available)
Admin Date: ___ / ___ / _____ Discharge Date: ___/___/____

Place of Birth: _____

Reason for testing *(check all that apply)*
☐ Symptoms of acute hepatitis
☐ Screening of asymptomatic patient with reported risk factors
☐ Screening of asymptomatic patient with no risk factor, e.g. patient request
☐ Evaluation of elevated liver enzymes
☐ Follow-up testing for previous marker of viral hepatitis
☐ Blood/Organ donor screening
☐ Unknown
☐ Other, specify _____

Y N U
☐ ☐ ☐ Is patient pregnant? If yes, Due Date _____
Diagnosis date: ___ / ___ / _____

Clinical Findings

Y N U
☐ ☐ ☐ Is patient symptomatic?
Illness Onset date: ___ /___ /_____
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Did the patient die from this illness?
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Abdominal pain/right upper quadrant pain
☐ ☐ ☐ Dark Urine
☐ ☐ ☐ Clay colored stool
☐ ☐ ☐ Anorexia
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ Fever

LABORATORY (Please submit copies of ALL Labs associated with this illness to state health department)

ALT Result_____ Upper Limits _____ Date: _____ AST Result_____ Upper Limits _____ Date: _____

Y N U
☐ ☐ ☐ Total antibody to hepatitis A virus (total anti-HAV)
☐ ☐ ☐ IgM antibody to hepatitis A virus (IgM anti-HAV)
☐ ☐ ☐ Hepatitis B surface antigen (HBsAg)
☐ ☐ ☐ Hepatitis B 'e' antigen (HBeAg)
☐ ☐ ☐ Total antibody to hepatitis B core antigen (Total anti-HBc)
☐ ☐ ☐ IgM antibody to hepatitis B core antigen (IgM anti-HBc)
☐ ☐ ☐ HBV DNA

Y N U
☐ ☐ ☐ Antibody to hepatitis C virus (anti-HCV)
☐ ☐ ☐ anti-HVC signal to cut-off ratio
☐ ☐ ☐ Supplemental anti-HCV assay (e.g. RIBA)
☐ ☐ ☐ HCV RNA (e.g. PCR)
☐ ☐ ☐ Antibody to hepatitis D virus (anti-HDV)
☐ ☐ ☐ Antibody to hepatitis E virus (anti-HEV)
☐ ☐ ☐

EPIDEMIOLOGIC

Case Status: ☐ Confirmed ☐ Probable ☐Suspect ☐Not a Case ☐Unknown
Diagnosis: ☐ Hepatitis A, Acute ☐ Hepatitis B, Acute ☐ Hepatitis B, Chronic X Perinatal Hepatitis B infection
☐ Hepatitis C, Acute ☐ Hepatitis C, Chronic (past or present) ☐ Hepatitis Delta ☐ Hepatitis E, Acute