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

Acute or Chronic 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: _____
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

AST Result_____ Upper Limits _____ Date: _____
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 ☐ Perinatal Hepatitis B infection
☐ Hepatitis C, Acute ☐ Hepatitis C, Chronic (past or present) ☐ Hepatitis Delta ☐ Hepatitis E, Acute

Complete this page for Acute cases only

HEPATITIS B EXPOSURES (based on the above exposure period)

DURING THE **6 WEEKS - 6 MONTHS** PRIOR TO ONSET OF SYMPTOMS WAS/DID THE PATIENT:

Y N U

☐ ☐ ☐ A contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?
Type of contact: _____
Specify other: _____

☐ ☐ ☐ Undergo hemodialysis?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Have an accidental stick or puncture with a needle or other object contaminated with blood?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Receive blood or blood products (transfusion)?
Date of Transfusion _____
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Receive any IV infusions and /or injections in the outpatient setting?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Have exposure to someone else's blood?
Specify other: _____
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Was the patient employed in a medical or dental field involving direct contact with human blood?
If yes, frequency of direct blood contact:
☐ Frequent (several times weekly) ☐ Infrequent

☐ ☐ ☐ Was the patient employed as a public safety worker (firefighter, law enforcement, or correctional officer) having direct contact with human blood?
If yes, frequency of direct blood contact:
☐ Frequent (several times weekly) ☐ Infrequent

☐ ☐ ☐ Did the patient receive t tattoo?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Did the patient have any part of their body pierced (other than ear)?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Did the patient have dental work or oral surgery?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Did the patient have surgery?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Was the patient hospitalized?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Was the patient a resident of a long term care facility?
If yes, see **Custom Specific Custom Fields** below

☐ ☐ ☐ Was the patient incarcerated for more than 24 hours?
If yes, see **Custom Specific Custom Fields** below

DURING THE **6 WEEKS - 6 MONTHS** PRIOR TO ONSET OF SYMPTOMS DID THE PATIENT:

Y N U

☐ ☐ ☐ Inject drugs not prescribed by a doctor?

☐ ☐ ☐ Use street drugs, but not inject?

ASK BOTH QUESTIONS REGARDLESS OF THE PATIENTS GENDER

How many Male sex partners did the patient have?
☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown

How many Female sex partners did the patient have?
☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown

DURING HIS OR HER LIFTIME WAS THE PATIENT EVER:

Y N U

☐ ☐ ☐ Treated for a sexually-transmitted disease
If yes, year of most recent treatment _____

☐ ☐ ☐ Was the patient incarcerated for longer than 6 months?
Year of most recent incarceration _____
length of most recent incarceration _____

VACCINE INFORMATION:

Y N U

☐ ☐ ☐ Did the patient ever receive hepatitis B vaccine?
If yes, how many shots?_____
In what year was the last shot received?_____

☐ ☐ ☐ Was the patient tested for antibody to HBsAG within 1-2-months after last dose?

☐ ☐ ☐ Was the serum anti-HBs>=10 IU/ml?
(answer 'Yes' if lab result reported was positive or reactive)

VACCINATION RECORD

Vaccine record information cannot be entered in the Investigation. Go to patient's event tab to enter.

DOSE 1
Date administered _____
Vaccine Administered _____
Vaccination ID _____

DOSE 2
Date administered _____
Vaccine Administered _____
Vaccination ID _____

DOSE 3
Date administered _____
Vaccine Administered _____
Vaccination ID _____

HEPATITIS B EXPOSURES (based on the above exposure period)

Y N U

☐ ☐ ☐ Did the patient receive a fingerstick (use of glucose meter, etc.)?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient have any outpatient procedure?
If yes, see **Custom Specific Fields** below

Y N U

☐ ☐ ☐ Was the patient a recipient of a transplanted organ or tissue?
If yes, see **Custom Specific Fields** below

CONDITION SPECIFIC CUSTOM FIELDS

Exposure Detail 1
If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 2
If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 3
If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 4
If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 5
If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 6
If yes to: _____
Date of Event or exposure_____
Facility/Provider name where event/exposure occurred
_____
City: _____ State: _____
Facility phone #: _____

PUBLIC HEALTH ISSUES/ACTIONS/ NOTES:

Y N U

☐ ☐ ☐ Patient has **NO** other hepatitis risk factors, **EXCEPT for a procedure received at a healthcare facility/setting within the incubation period** (*i.e*. possible healthcare-associated infection)

☐ ☐ ☐ Patient lost to follow-up

☐ ☐ ☐ Other, specify _____

Y N U

☐ ☐ ☐ Investigate as possible healthcare-associated infection

☐ ☐ ☐ Patient education/counseling provided.
If yes, indicate date __/__/____.

☐ ☐ ☐ Offer hepatitis A and/or B vaccine (as necessary)

☐ ☐ ☐ Other, specify _____