Washington State Department of HEALTH

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 childs) 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) _____ WAIIS 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 ___/___/___

Hepatitis B-Chronic case defining or required variables are in **bold.** Answers are: Yes, No, Unknown to case

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.