Infectious Disease Epidemiology and Outbreak Response Bureau
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Maryland
DEPARTMENT OF HEALTH

# HEPATITIS B ACUTE CASE REPORT FORM

**Final Case Status:**
☐ CONFIRMED
☐ PROBABLE
☐ NOT A CASE

Investigation ID: _____

Investigator: _____

Last Name: _____ First Name: _____ Middle Name: _____

Alias or Maiden Name: _____

Address: Street: _____ City: _____ Phone: _____ Zip Code: _____

Jurisdiction/County: _____ Investigation Start Date: __ __ / __ __ / __ __ __ __

Source of Report Lab ICP Physician Other: _____ Date of Report: _____ / _____ / _____ MMWR Week: _____

Name of Source: _____ Phone: _____

Reporting Provider: _____ Phone: _____ MMWR Year: _____

## DEMOGRAPHIC INFORMATION

**RACE: (check all that apply)**

❑ Amer Indian or Alaska Native ❑ Black or African American ❑ White

❑ Asian ❑ Native Hawaiian or Pacific Islander ❑ Other Race, specify _____

**ETHNICITY:**

Hispanic..... ❑

Non-Hispanic ..... ❑

Other/Unknown..... ❑

**SEX:** Male ❑ Female ❑ Unk ❑

**PLACE OF BIRTH:** ❑ USA ❑ Other: _____

**DATE OF BIRTH:** M M / D D / Y Y Y Y

**AGE:** __ __ __ (years) (00 = <1yr , 999 = Unk)

## CLINICAL & DIAGNOSTIC DATA

**REASON FOR TESTING: (check all that apply)**

❑ Year of birth (1945-1965)
❑ Screening of asymptomatic patient with reported risk factors
❑ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
❑ Follow-up testing for previous marker of viral hepatitis
❑ Symptoms of acute hepatitis
❑ Blood/organ donor screening
❑ Evaluation of elevated liver enzymes
❑ Other: specify: _____
❑ Prenatal screening
❑ Unknown

### CLINICAL DATA:

| Diagnosis date: M M / D D / Y Y Y Y | Yes | No | Unk |
|---|---|---|---|
| • Was the patient jaundiced? | ❑ | ❑ | ❑ |
| • Did the patient have other symptoms? | ❑ | ❑ | ❑ |
| if yes, onset date: M M / D D / Y Y Y Y | | | |
| • Hospitalized for hepatitis? | ❑ | ❑ | ❑ |
| Hospital name and dates: _____ | | | |
| • Was the patient pregnant? | ❑ | ❑ | ❑ |
| Due date: M M / D D / Y Y Y Y | | | |
| • Did the patient die from hepatitis? | ❑ | ❑ | ❑ |
| Death date: M M / D D / Y Y Y Y | | | |
| • Was the patient aware they had hepatitis prior to testing? | ❑ | ❑ | ❑ |
| • If the patient had a **negative** hepatitis related test in the **prior 6 months** document lab name, date, and result type _____ | | | |
| • If applicable, list provider of care for hepatitis: _____ | | | |
| • Does the patient have diabetes? | ❑ | ❑ | ❑ |
| Diabetes diagnosis date: M M / D D / Y Y Y Y | | | |

### LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

• ALT (SGPT) Result _____ Collection Date (ALT): __ __ / __ __ / __ __

• AST (SGOT) Result _____ Collection Date (AST): __ __ / __ __ / __ __

| | Yes | No | Unk |
|---|---|---|---|
| • Elevated Total Bilirubin (>= 3.0mg/dl)? | ❑ | ❑ | ❑ |

Collection Date (Total Bilirubin): __ __ / __ __ / __ __

### DIAGNOSTIC TESTS:

| | Pos | Neg | Unk |
|---|---|---|---|
| • Total antibody to Hep A virus (total anti-HAV) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • IgM antibody to Hep A virus (IgM anti-HAV) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis B surface antigen (HBsAg) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Total antibody to hepatitis B core antigen (total anti-HBc) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis B "e" antigen (HBeAg) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • IgM antibody to hepatitis B core antigen (IgM anti-HBc) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis B DNA (Hep B NAT) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Antibody to hepatitis C virus (anti-HCV) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis C virus RNA | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis C genotype _____ Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Antibody to hepatitis D virus (anti-HDV) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis D RNA | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Antibody to hepatitis E virus (IgM anti-HEV) | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |
| • Hepatitis E RNA | ❑ | ❑ | ❑ |
| Collection Date: __ __ / __ __ / __ __ __ __ | | | |

## Patient History — Acute Hepatitis B

**Investigation ID:** _____

| During the **6 weeks – 6 months** prior to onset of symptoms w as the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection? | Yes | No | Unk |
|---|---|---|---|
| | ❑ | ❑ | ❑ |
| If yes, type of contact | | | |
| Sexual | ❑ | | |
| Household (non-sexual) | ❑ | | |
| Other: _____ | ❑ | | |

| During the **6 weeks – 6 months** prior to onset of symptoms<br>**Did the patient:** | Yes | No | Unk |
|---|---|---|---|
| • Undergo hemodialysis? | ❑ | ❑ | ❑ |
| Specify dates, name, and address of facility _____ | | | |
| • Receive an organ transplant? | ❑ | ❑ | ❑ |
| Specify organ type _____ | | | |
| Name and address of facility _____ | | | |
| • Receive any IV infusions and/or injections in the outpatient setting | ❑ | ❑ | ❑ |
| Name and address of facility _____ | | | |
| • Have an accidental stick or puncture with a needle or other object contaminated with blood? | ❑ | ❑ | ❑ |
| • Receive blood or blood products [transfusion] | ❑ | ❑ | ❑ |
| If yes, when? M M/ D D / Y Y Y Y | | | |
| Name and address of facility _____ | | | |
| • Have other exposure to someone else's blood | ❑ | ❑ | ❑ |
| If yes, specify _____ | | | |
| • Have shared blood sugar kits or devices such as lancets? | ❑ | ❑ | ❑ |
| • Have employment in a medical or dental field involving direct contact with human blood? | ❑ | ❑ | ❑ |
| If yes, frequency of direct blood contact? ❑ Frequent (several times w eekly) ❑ Infrequent | | | |
| • Have employment as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood? | ❑ | ❑ | ❑ |
| If yes, frequency of direct blood contact? ❑ Frequent (several times weekly) ❑ Infrequent | | | |

| | Yes | No | Unk |
|---|---|---|---|
| • Did the patient receive a tattoo? | ❑ | ❑ | ❑ |
| Where was the tattooing performed? (select all that apply) | | | |
| ❑ commercial parlor/shop | | | |
| ❑ correctional facility ❑ other _____ | | | |
| • Did the patient have any part of their body pierced (other than ear)? | ❑ | ❑ | ❑ |
| Where was the piercing performed? (select all that apply) | | | |
| ❑ commercial parlor/shop | | | |
| ❑ correctional facility ❑ other _____ | | | |

| During the **6 weeks – 6 months** prior to onset of symptoms<br>**Did the patient:** | Yes | No | Unk |
|---|---|---|---|
| • Inject drugs not prescribed by a doctor? | ❑ | ❑ | ❑ |
| • Use street drugs but not inject? | ❑ | ❑ | ❑ |
| • What kind of drugs were used? _____ | | | |
| • Have a history of ETOH abuse? | ❑ | ❑ | ❑ |
| • Have dental work or oral surgery? | ❑ | ❑ | ❑ |
| Name and address of facility _____ | | | |
| • Have surgery (other than oral) ? | ❑ | ❑ | ❑ |
| Name and address of facility _____ | | | |
| • Have residence in a long term care facility? | ❑ | ❑ | ❑ |
| • Have incarceration for longer than 24 hours? | ❑ | ❑ | ❑ |
| if yes, what type of facility (check all that apply) | | | |
| prison | ❑ | | |
| jail | ❑ | | |
| juvenile facility | ❑ | | |
| • During his/her lifetime, **EVER** incarcerated for longer than 6 months? | ❑ | ❑ | ❑ |
| if yes, what year was the most recent incarceration? __ Y Y Y Y | | | |
| and for how long? M M M (mos) | | | |

What is the sexual preference of the patient?

❑ Heterosexual ❑ Homosexual
❑ Bisexual ❑ Unknown

Ask both of the following questions regardless of the patient's gender.

| In the **6 months** before symptom onset, how many | 0 | 1 | 2–5 | >5 | Unk |
|---|---|---|---|---|---|
| male sex partners did the patient have? | ❑ | ❑ | ❑ | ❑ | ❑ |
| female sex partners did the patient have? | ❑ | ❑ | ❑ | ❑ | ❑ |

| | Yes | No | Unk |
|---|---|---|---|
| • Was the patient **EVER** treated for a sexually-transmitted disease? | ❑ | ❑ | ❑ |
| if yes, in what year was the most recent treatment? Y Y Y Y | | | |

| | Yes | No | Unk |
|---|---|---|---|
| • Did the patient ever receive hepatitis B vaccine? | ❑ | ❑ | ❑ |
| | 1 | 2 | 3+ |
| if yes, how many doses? | ❑ | ❑ | ❑ |
| • In what year w as the last dose received? __ __ __ __ | | | |
| • Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose? | ❑ | ❑ | ❑ |
| If yes, was the serum anti-HBs ≥ 10ml I /Uml? | ❑ | ❑ | ❑ |
| (answer 'yes' if the laboratory result was reported as 'positive' or 'reactive') | | | |

**COMMENTS**

| |
|---|
| |
| |
| |
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| |

**PERSON COMPLETING FORM:** _____ **DATE:** ____ / ____ / _____