

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

**HEPATITIS B, ACUTE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 15**

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

LABORATORY TESTING: Laboratory test results to support hepatitis B case definition. Give details below.

Collection Date	Result Date	Type of Test	Results (include serogroup/type)	Reference Range	Lab name—City/State
		IgM anti-HAV (IgM antibody to hepatitis A virus)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		HBs Ag (Hepatitis B surface antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		anti-HBs (Hepatitis B surface antibody)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		Total anti-HBc (Total antibody to hepatitis B core antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		IgM anti-HBc (IgM antibody to hepatitis B core antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		HBe Ag (Hepatitis B e antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		Anti-HBe (Antibody to hepatitis B e antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		Hepatitis B DNA	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		anti-HDV (Anti-hepatitis D virus)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		

REASON FOR TESTING

Why was the patient tested for this condition?

Check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Symptoms of acute hepatitis | <input type="checkbox"/> Prenatal screening | <input type="checkbox"/> Household contact to a person reported with this disease |
| <input type="checkbox"/> Screening of asymptomatic person with reported risk factor(s) | <input type="checkbox"/> Evaluation of elevated liver enzymes | <input type="checkbox"/> Sexual contact to a person reported with this disease |
| <input type="checkbox"/> Screening of asymptomatic person with no risk factor(s) | <input type="checkbox"/> Blood / organ / tissue donor screening | <input type="checkbox"/> Refugee |
| | <input type="checkbox"/> Follow-up for previous marker for viral hepatitis | <input type="checkbox"/> Infant born to HBsAg positive woman |
| | <input type="checkbox"/> Follow-up of acute HBV | <input type="checkbox"/> Other, specify: _____ |
| | <input type="checkbox"/> Follow-up of HBV carrier status | <input type="checkbox"/> Unknown |
| | <input type="checkbox"/> Blood / body fluid exposure | |

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

CLINICAL FINDINGS

Fatigue or malaise or weakness Y N U
 Loss of appetite (anorexia) Y N U
 Weight loss with illness Y N U
 Headache Y N U
 Joint pains (arthralgias) Y N U
 Arthritis Y N U
 Muscle aches/pains (myalgias) Y N U
 Nausea Y N U
 Vomiting Y N U
 Abdominal pain or cramps Y N U
 Diarrhea Y N U
 Enlarged liver (hepatomegaly) Y N U
 Hepatitis (inflamed liver) Y N U
 Chronic Active Hepatitis Y N U
 Hepatitis D infection Y N U
 Cirrhosis Y N U
 Elevated liver enzymes Y N U
 ALT Level _____ Date ____/____/____
 AST Level _____ Date ____/____/____
 Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) Y N U
 Onset date (mm/dd/yyyy): _____
 Dark urine (bilirubinuria) Y N U
 Onset date (mm/dd/yyyy): _____
 Acute liver failure Y N U
 Hepatocellular carcinoma Y N U
 Cholecystitis Y N U
 Pancreatitis Y N U

PREGNANCY

Is the patient currently pregnant? Y N
 Estimated delivery date ____/____/____
 (Required if currently pregnant)
 For the pregnancy listed above enter the following information:
 Date of Delivery or Pregnancy Termination ____/____/____
 Pregnancy Outcome
 Live Single Birth
 Live Multiple Birth
 Still Birth/ Fetal Death/ Fetal Demise (≥20 weeks gestation)
 Miscarriage/Spontaneous Abortion (<20 weeks gestation)
 Elective Abortion

Has this person given birth in the last 24 months?
 (Other than pregnancy listed above) Yes No
 For each live birth in the last 24 months please record the following information:
 Date of Birth ____/____/____
 Has this infant been entered in NC EDSS as a Hepatitis B perinatal contact? Yes No
 Date of Birth ____/____/____
 Has this infant been entered in NC EDSS as a Hepatitis B perinatal contact? Yes No

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U
 1. Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____ - _____
 Admit date (mm/dd/yyyy): ____/____/____
 Discharge date (mm/dd/yyyy): ____/____/____
 ICU admission? Y N U

If applicable:
 2. Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____ - _____
 Admit date (mm/dd/yyyy): ____/____/____
 Discharge date (mm/dd/yyyy): ____/____/____
 ICU admission? Y N U

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N U
 Check all that apply:
 Work Sexual behavior
 Child care Blood and Body Fluid
 School Other
 Date control measures issued: _____
 Date control measures ended: _____
 Was patient compliant with control measures? Y N U
 Were written isolation orders issued? Y N U
 If yes, where was the patient isolated? _____
 Date isolation started? _____
 Date isolation ended? _____
 Was the patient compliant with isolation? Y N U
 Were written quarantine orders issued? Y N U
 If yes, where was the patient quarantined? _____
 Date quarantine started? _____
 Date quarantine ended? _____
 Was the patient compliant with quarantine? Y N U

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 Foreign Visitor
 Refugee
 Recent Immigrant
 Foreign Adoptee
 Other, specify: _____
 Did patient have a travel history during the six months prior to symptom onset until HBsAg negative? Y N U
 List dates of travel and destinations: _____

 Notes:

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____
 Survived? Y N U
 Died? Y N U
 Died from this illness? Y N U
 Date of death (mm/dd/yyyy): ____/____/____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: _____
 Is the patient acutely ill with hepatitis B AND a primary caregiver for an infant less than 12 months of age? Y N U
 Has the infant(s) been assessed for immunoprophylaxis? Y N U
 Notes:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 6 weeks to 6 months prior to onset of symptoms, did the patient have any of the following risks:
 Have blood or blood products transfusion? Y N U
 When and where? _____
 Have dental or oral surgery? Y N U
 Have dialysis? Y N U
 Have hospitalization? Y N U
 Have IV injections in the outpatient setting? Y N U
 Reside in a long term care facility? Y N U
 Have surgery other than oral surgery? Y N U
 Employed in a medical/dental field involving direct contact with human blood? Y N U
 Frequency of direct blood contact:
 Frequent (several times weekly)
 Infrequent
 Employed as a public safety worker (fire fighter, law enforcement, correctional officer) Y N U
 Frequency of direct blood contact:
 Frequent (several times weekly)
 Infrequent
 Have accidental stick or puncture with a needle or other object contaminated with blood? Y N U
 Have exposure to someone else's blood? Y N U
 Specify: _____
 Did someone else have exposure to patient's blood? Y N U
 Specify: _____
 Give details for all "yes" responses above:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

BEHAVIORAL RISK & CONGREGATE LIVING

During the patient's lifetime, has the patient ever been incarcerated for longer than 6 months? Y N U
 What year was the most recent incarceration? _____
 For how long? (xx months) _____

During the 6 weeks to 6 months prior to onset of symptoms, did the patient have any of the following risks:

Was the patient incarcerated for longer than 24 hours? Y N U
 If yes, what type of facility (check all that apply):
 Jail
 Prison
 Juvenile

Receive a tattoo? Y N U
 Where was tattooing performed?
 Commercial parlor/shop
 Correctional facility
 Other, specify: _____
 Unknown

Receive body piercing? Y N U
 Specify: _____

Ear piercing? Y N U
 Where was ear piercing performed?
 Commercial parlor/shop
 Correctional facility
 Other, specify: _____
 Unknown

Piercing other than ear? Y N U
 Where was that piercing performed?
 Commercial parlor/shop
 Correctional facility
 Other, specify: _____
 Unknown

Inject drugs not prescribed by a doctor? Y N U

Use street drugs but not inject? Y N U
 Have contact with a person who was confirmed/suspected of having acute or chronic hepatitis B virus infection? Y N U
 If yes, type of contact:
 Sexual
 Household (non-sexual)
 Other

Has the patient ever been treated for a sexually transmitted disease? Y N U
 In what year was the most recent treatment? _____
 Have sexual contact with a FEMALE? Y N U
 Number of female sex partners:
 1 2-5 >5 U
 Have sexual contact with a MALE? Y N U
 Number of male sex partners:
 1 2-5 >5 U

During the six months prior to symptom onset until HBsAg negative did the patient live in any congregate living facilities such as correctional facilities, dormitories, sororities, fraternities, barracks, camps, commune, boarding school, shelter etc?
 Y N U
 Facility: _____
 College or University: _____
 City: _____
 County: _____
 State: _____
 Country: _____
 Phone Number: (____) _____
 Date of contact: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed: _____

Notes on medical record verification: _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 Specify: _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown

Is the patient part of an outbreak of this disease? Y N U

Notes regarding setting of exposure: _____

VACCINES

Has patient ever received hepatitis B vaccine? Y N U
 Specify type:
 Vaccine Type Known: _____
 Vaccine Type Unknown (NOS)

How many shots? (1/2/3+): _____
 In what year was last dose received? (YYYY): _____
 Dates of hepatitis B vaccine:
 (mm/dd/yyyy): _____
 (mm/dd/yyyy): _____
 (mm/dd/yyyy): _____
 Vaccination dates unknown

Was patient tested for antibody to HBsAg (anti-HBs) at 1-2 months after the last vaccine dose? Y N U
 If yes, was the serum anti-HBs 10 mIU/ml or greater? Y N U

Hepatitis B, Acute

2000 CDC Case Definition

Clinical case definition

An acute illness with a) discrete onset of symptoms **and** b) jaundice or elevated serum aminotransferase levels

Laboratory criteria for diagnosis:

IgM antibody to hepatitis B core antigen (anti-HBc) positive
or hepatitis B surface antigen (HBsAg) positive
IgM anti-HAV negative (if done)

Case classification

Confirmed: a case that meets the clinical case definition and is laboratory confirmed