TDH

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Hepatitis B Case Track Record

FINAL STATUS:
G CONFIRMED ACUTE
G CONFIRMED CHRONIC
G RULED OUT/ DROPPED

NETSS CASE # ____________

Patient's Name: ______________________ (last) ______________________ (first)

Patient's Occupation: ____________________________

Address: ____________________________

City: ______________ County: ____________ Zip: ________

Region: _______ Phone:( ) ______________________

Parent/Guardian: ____________________________

Physician: ______________ Phone:( ) ____________

Address: ____________________________

Reported By: ____________________________

Agency: ____________________________

Phone:( ) ____________________________

Date: _____/_____/_____

Report Given to: ____________________________

Organization: ____________________________

Phone:( ) ____________________________

DEMOGRAPHICS: *DATE OF BIRTH:* _____/_____/_____ *AGE:* ______ *SEX:* G Male G Female G Unknown

RACE: G White G Black G Asian/Pacific Islander G Native American G Unknown G Other: ______________

HISPANIC: G Yes G No G Unknown

If female, is patient currently pregnant? G Yes G No G Unknown Obstetrician's name, address, and phone #: ______________

If yes, estimated date and location of delivery: ____/____/____ ______________________________

CLINICAL DATA:

Date of first symptom: ____/____/____ Diagnosis Date: _ __/__ _/_ __

Was the patient jaundiced? G Yes G No
Was the patient hospitalized for hepatitis B? G Yes G No
Did the patient die from hepatitis B? G Yes G No

Hospitalized at: ______________________

Admitted: ____/____/____ Discharged: ____/____/____

VACCINATION HISTORY: *VACCINATED:* G Yes G No G Unknown

1 HepB: ____/____/____ Manufacturer: ______________ 4 HepB: ____/____/____ Manufacturer: ______________

2 HepB: ____/____/____ Manufacturer: ______________ 5 HepB: ____/____/____ Manufacturer: ______________

3 HepB: ____/____/____ Manufacturer: ______________ 6 HepB: ____/____/____ Manufacturer: ______________

If no, indicate reason: G Religious Exemption G Medical Contraindication G Evidence of Immunity G Previous Disease - Lab Confirmed

G Previous Disease - MD Diagnosed G Under Age G Parental Refusal G Unknown G Other: ______________________

POST-VACCINATION TESTING: G Yes G No G Unknown
1 Anti-HBs:____/____/____ G Pos G Neg G Unknown HBsAg:____/____/____ G Pos G Neg G Unknown
2 Anti-HBs:____/____/____ G Pos G Neg G Unknown HBsAg:____/____/____ G Pos G Neg G Unknown

LABORATORY DATA:
Laboratory Name(s): ______________________________________

Test				
Hepatitis B surface antigen (HBsAg)	G Pos	G Neg	G Not Tested/Unknown	Date:____/____/____
IgM Hepatitis B core antibody (IgM anti-HBc)	G Pos	G Neg	G Not Tested/Unknown	Date:____/____/____
Hepatitis B e antigen (HBeAg)	G Pos	G Neg	G Not Tested/Unknown	Date:____/____/____
Antibody to HBe (Anti-HBe)	G Pos	G Neg	G Not Tested/Unknown	Date:____/____/____
Antibody to HBc (Anti-HBc)	G Pos	G Neg	G Not Tested/Unknown	Date:____/____/____

Other test results: ______________________________ Date:____/____/____

During the 6 weeks-6 months prior to illness:

Was the patient a contact of a confirmed or suspected acute or chronic hepatitis B case? G Yes G No G Unknown
If yes, type of contact: G Sexual G Household (non-sexual) G Other
Was the patient employed in a medical, dental, or other field involving contact with human blood? G Yes G No G Unknown
If yes, degree of blood contact: G Frequent (several times weekly) G Infrequent
Did the patient receive blood or blood products (transfusion)? G Yes G No G Unknown
If yes, specify date(s) received: ____/____/____ to ____/____/____
Was patient associated with a dialysis or kidney transplant unit? G Yes G No G Unknown
If yes, G Patient G Employee G Contact of patient or employee
Did the patient use needles for injection of drugs? G Yes G No G Unknown
What was the patient's sexual preference? G Heterosexual G Homosexual G Bisexual G Unknown
How many different sexual partners did the patient have? G None G One G 2-5 G More than 5 G Unknown
Did the patient have
dental work or oral surgery? G Yes G No G Unknown
other surgery? G Yes G No G Unknown
acupuncture? G Yes G No G Unknown
tattooing? G Yes G No G Unknown
an accidental stick or puncture with a needle or other object containing blood? G Yes G No G Unknown

Non-sexual Household and Sexual Contacts Requiring Prophylaxis:

Name	Relation to Case	Age	HBIG	HB Vaccine
______________	______________	_______	____/____/____	____/____/____
______________	______________	_______	____/____/____	____/____/____
______________	______________	_______	____/____/____	____/____/____
______________	______________	_______	____/____/____	____/____/____

Additional Risk Factor Information:
If patient was transfused, name of blood center:______________________________
Number of units of whole blood, packed RBC or frozen RBC received______________________ ______________
Specify type of blood product (e.g. albumin, fibrinogen, factor VIII, etc.)______________________________

Additional Risk Factor Information (continued):
If blood donor, name, address, and phone # of donation or plasmapheresis center:______________________________

Donation Date(s): ______________________________

Name, address, and phone # of dialysis center:
____

Name, address, and phone # of dentist or oral surgeon:
____

If other surgery performed, name, address, and phone # of location:
____

Name, address, and phone # of acupuncturist or tattoo parlor:
____

Control Measures (check all that apply):

G Notified blood center(s)
G Notified dialysis center, surgeon(s), acupuncturist, and/or tattoo parlor
G Disinfected all equipment contaminated with blood or infectious body fluids
G Vaccinated susceptible contacts
G Notified delivery hospital and obstetrician if women is pregnant
G Vaccinated infant born to HBsAg-positive women

Investigator's Name: ______________________________ Agency Name:______________________________

Phone:( ) ________________ Date Investigation Initiated: _____/_____/_____ Date Investigation Completed: _____/_____/_____

Comments: