Infectious Disease Control Unit, Texas Department of State Health Services
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Hepatitis B Case Track Record

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

NBS PATIENT ID#: _____

Patient's Name: _____
last first
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:* ☐ Male ☐ Female ☐ Unknown
RACE: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Native American ☐ Unknown ☐ Other:_____
HISPANIC: ☐ Yes ☐ No ☐ Unknown

If female, is patient currently pregnant? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No Hospitalized at: _____
Was the patient hospitalized for hepatitis B? ☐ Yes ☐ No
Did the patient die from hepatitis B? ☐ Yes ☐ No Admitted: ____/____/____ Discharged: ____/____/____

Vaccination History: *VACCINATED:* ☐ Yes ☐ No ☐ Unknown

1 HepB: ____/____/____ Manufacturer: _____ 4 HepB: ____/____/____ Manufacturer: _____
2 HepB: ____/____/____ Manufacturer: _____ 5 HepB: ____/____/____ Manufacturer: _____
3 HepB: ____/____/____ Manufacturer: _____ 6 HepB: ____/____/____ Manufacturer: _____

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

☐ Previous Disease - MD Diagnosed ☐ Under Age ☐ Parental Refusal ☐ Unknown ☐ Other: _____

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

Laboratory Data:
Laboratory Name(s): _____

Hepatitis B surface antigen (HBsAg)	☐ Pos	☐ Neg	☐ Not Tested/Unknown	Date:____/____/____
IgM Hepatitis B core antibody (IgM anti-HBc)	☐ Pos	☐ Neg	☐ Not Tested/Unknown	Date:____/____/____
Hepatitis B e antigen (HBeAg)	☐ Pos	☐ Neg	☐ Not Tested/Unknown	Date:____/____/____
Antibody to HBe (Anti-HBe)	☐ Pos	☐ Neg	☐ Not Tested/Unknown	Date:____/____/____
Antibody to HBc (Anti-HBc)	☐ Pos	☐ Neg	☐ 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? ☐ Yes ☐ No ☐ Unknown
If yes, type of contact: ☐ Sexual ☐ Household (non-sexual) ☐ Other
Was the patient employed in a medical, dental, or other field involving contact with human blood? ☐ Yes ☐ No ☐ Unknown
If yes, degree of blood contact: ☐ Frequent (several times weekly) ☐ Infrequent
Did the patient receive blood or blood products (transfusion)? ☐ Yes ☐ No ☐ Unknown
If yes, specify date(s) received: ____/____/____ to ____/____/____
Was patient associated with a dialysis or kidney transplant unit? ☐ Yes ☐ No ☐ Unknown
If yes, ☐ Patient ☐ Employee ☐ Contact of patient or employee
Did the patient use needles for injection of drugs? ☐ Yes ☐ No ☐ Unknown
What was the patient's sexual preference? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Unknown
How many different sexual partners did the patient have? ☐ None ☐ One ☐ 2-5 ☐ More than 5 ☐ Unknown
Did the patient have
dental work or oral surgery? ☐ Yes ☐ No ☐ Unknown
other surgery? ☐ Yes ☐ No ☐ Unknown
acupuncture? ☐ Yes ☐ No ☐ Unknown
tattooing? ☐ Yes ☐ No ☐ Unknown
an accidental stick or puncture with a needle or other object containing blood? ☐ Yes ☐ No ☐ 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):

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

Investigator's Name: _____ Agency name: _____

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

COMMENTS: