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

REMINDER to Local Health Department staff: 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)	☐ Positive ☐ Negative ☐ Unknown		
		HBs Ag (Hepatitis B surface antigen)	☐ Positive ☐ Negative ☐ Unknown		
		anti–HBs (Hepatitis B surface antibody)	☐ Positive ☐ Negative ☐ Unknown		
		Total anti–HBc (Total antibody to hepatitis B core antigen)	☐ Positive ☐ Negative ☐ Unknown		
		IgM anti-HBc (IgM antIbody to hepatitis B core antigen)	☐ Positive ☐ Negative ☐ Unknown		
		HBe Ag (Hepatitis B e antigen)	☐ Positive ☐ Negative ☐ Unknown		
		Anti –HBe (Antibody to hepatitis B e antigen)	☐ Positive ☐ Negative ☐ Unknown		
		Hepatitis B DNA	☐ Positive ☐ Negative ☐ Unknown		
		anti-HDV (Anti-hepatitis D virus)	☐ Positive ☐ Negative ☐ Unknown		
		ALT (SGP T)			
		AST (SGOT)			

REASON FOR TESTING

Why was the patient tested for this condition?
Check all that apply:

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

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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): _____
- (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

2012 Case Definition

CSTE Position Statement Number: 11-ID-03

Clinical Description

An acute illness with a discrete onset of any sign or symptom* consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain) and either a) jaundice, or b) elevated serum alanine aminotransferase (ALT) levels >100 IU/L.

*A documented negative hepatitis B surface antigen (HBsAg) laboratory test result within 6 months prior to a positive test (either HBsAg, hepatitis B “e” antigen (HBeAg), or hepatitis B virus nucleic acid testing (HBV NAT) including genotype) result does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory Criteria for Diagnosis

- HBsAg positive, AND
- Immunoglobulin M (IgM) antibody to hepatitis B core antigen (IgM anti-HBc) positive (if done)

Case Classification

Confirmed

A case that meets the clinical case definition is laboratory confirmed, and is not known to have chronic hepatitis B.