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

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

HEPATITIS B, PERINATALLY ACQUIRED
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 116

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		

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:

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
Right upper quadrant pain ☐ 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
Cirrhosis ☐ Y ☐ N ☐ U
Elevated liver enzymes ☐ Y ☐ N ☐ U
AST Level _____ Date _____
ALT 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

(CONTINUED NEXT PAGE)

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

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE (CONTINUED)

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

MATERNAL INFORMATION

Biologic mother's race:
- ☐ American Indian Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian Pacific Islander
- ☐ White
- ☐ Other, specify:_____
- ☐ Unknown

Biologic mother's ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Other/Unknown

Was mother of this infant born outside the USA? ☐ Y ☐ N ☐ U

Specify country:_____

Was the biologic mother confirmed HBsAg positive prior to, or at the time of, delivery? ☐ Y ☐ N ☐ U

Was the biologic mother confirmed HBsAg positive after delivery? ☐ Y ☐ N ☐ U

Date of HBsAg positive test result (mm/dd/yyyy):_____

Infant's country of birth:
- ☐ USA
- ☐ Other, specify country:

_____

If born in USA, what state was infant born in:
- ☐ NC
- ☐ Other, specify state: _____

TREATMENT

Did the patient receive hepatitis B immune globulin (HBIG)? ☐ Y ☐ N ☐ U

Date received (mm/dd/yyyy):_____

Was HBIG administered within 12 hrs. of birth? ☐ Y ☐ N ☐ U

If no, was first dose of vaccine administered within 1 calendar day of birth ☐ Y ☐ N ☐ U

If no, was HBV vaccine administered within 7 days of birth? ☐ Y ☐ N ☐ U

VACCINE

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

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):_____/_____/_____

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ Other, specify: _____

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: (_____)_____

Notes:

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness? ☐ Y ☐ N ☐ U

1. Hospital name:_____

City, State: _____

Hospital contact name: _____

Phone:(_____)_____

Admit date (mm/dd/yyyy) _____/_____/_____

Discharge date (mm/dd/yyyy) _____/_____/_____

If applicable:

2. Hospital name:_____

City, State: _____

Hospital contact name: _____

Phone: _____

Admit date (mm/dd/yyyy) _____/_____/_____

Discharge date (mm/dd/yyyy) _____/_____/_____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N ☐ U

Check all that apply:
- ☐ Work
- ☐ Child care
- ☐ School
- ☐ Sexual behavior
- ☐ Blood and Body Fluid
- ☐ 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

BEHAVIORAL RISK & CONGREGATE LIVING

During the six months prior to HBsAg positive to 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:_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the six months prior to HBsAg positive to HBsAg negative, did someone else have exposure to patient's blood? ☐ Y ☐ N ☐ U

Specify below.

During the 6 weeks to 6 months prior to onset of symptoms,were there other blood and body fluid exposures? ☐ Y ☐ N ☐ U

Specify below.

Notes/ Details:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

Specify _____

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:

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

Notes regarding setting of exposure:

Hepatitis, Viral, Perinatal Hepatitis B Virus Infection Acquired in the United States or U.S. Territories

1995 CDC Case Definition

Clinical case definition

Perinatal hepatitis B in the newborn may range from asymptomatic to fulminant hepatitis.

Laboratory criteria for diagnosis:

- Hepatitis B surface antigen (HBsAg) positive

Case classification

HBsAg positivity in any infant aged >1-24 months who was born in the United States or in U.S. territories to an HBsAg-positive mother