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, CHRONIC CARRIER
## Confidential Communicable Disease Report—Part 2
## NC DISEASE CODE: 115

**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

**PREGNANCY**
Is the patient currently pregnant? ☐ Yes ☐ No
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?** ☐ 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) ____/____/____

**Notes:**

## 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

## 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: _____

**Notes:**

## 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:**

## HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

**During the six months prior to positive serology (HBsAg, HBeAg, or HBV DNA) until negative HBsAg, did the patient have any of the following risks:**
Dental or oral surgery? ☐ Y ☐ N ☐ U
Dialysis? ☐ Y ☐ N ☐ U
Hospitalization? ☐ Y ☐ N ☐ U
Reside in a long term care facility? ☐ Y ☐ N ☐ U
Employment in a medical/dental field involving direct contact with human blood? ☐ Y ☐ N ☐ U
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 six months prior to positive serology (HBsAg, HBeAg, or HBV DNA) until negative HBsAg 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: _____

**During the six months prior to positive serology (HBsAg, HBeAg, or HBV DNA) until negative HBsAg, did the patient have any of the following risks:**

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

Have sexual contact with a person who was confirmed/suspected of having acute or chronic hepatitis B virus infection? ☐Y ☐N ☐U

Specify number of partners: ☐1 ☐2–5 ☐>5 ☐U

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

## 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

NOTES:

## 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 B, Chronic

## 2012 Case Definition

**CSTE Position Statement Number: 11-ID-04**

## Clinical Description

No symptoms are required. Persons with chronic hepatitis B virus (HBV) infection may have no evidence of liver disease or may have a spectrum of disease ranging from chronic hepatitis to cirrhosis or liver cancer.

## Laboratory Criteria for Diagnosis

- Immunoglobulin M (IgM) antibodies to hepatitis B core antigen (IgM anti-HBc) negative AND a positive result on one of the following tests: hepatitis B surface antigen (HBsAg), hepatitis B e antigen (HBeAg), or nucleic acid test for hepatitis B virus DNA (including qualitative, quantitative and genotype testing), OR
- HBsAg positive or nucleic acid test for HBV DNA positive (including qualitative, quantitative and genotype testing) or HBeAg positive two times at least 6 months apart (Any combination of these tests performed 6 months apart is acceptable)

## Case Classification

**Probable**

A person with a single HBsAg positive or HBV DNA positive (including qualitative, quantitative and genotype testing) or HBeAg positive lab result and does not meet the case definition for acute hepatitis B.

**Confirmed**

A person who meets either of the above laboratory criteria for diagnosis.

**Comment**

Multiple laboratory tests indicative of chronic HBV infection may be performed simultaneously on the same patient specimen as part of a “hepatitis panel.” Testing performed in this manner may lead to seemingly discordant results, e.g., HBsAg-negative AND HBV DNA-positive. For the purposes of this case definition, any positive result among the three laboratory tests mentioned above is acceptable, regardless of other testing results. Negative HBeAg results and HBV DNA levels below positive cutoff level do not confirm the absence of HBV infection.