COUNTY OF LOS ANGELES
Public Health

VIRAL HEPATITIS B CASE REPORT

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
www.lapublichealth.org/acd

IRIS ID: ________________________________

PATIENT INFORMATION

Patient Name - Last	First	Middle	Date of Birth	Age
Address - Number, Street	City		State	Zip Code
Telephone Number Home / Work / Cell	Email		Country of Birth	Date of Arrival

Patient's current gender identity? (check one)
☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: __________________________ ☐ Prefer not to state

Patient's sex at birth? (check one)
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: __________ ☐ Prefer not to answer

Patient's Sexual Orientation
☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: ____
☐ Don't understand the question ☐ Prefer not to answer

Patient's Race or Ethnicity (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Some other race; specify: _________________________ ☐ Refused
If Asian or Native Hawaiian/Other Pacific Islander, specify nationalities/ethnic groups: ____

Occupation, school, and/or volunteer (city/zip code)
Homeless? ☐ Yes ☐ No
Sensitive Occupation/Situation (S.O.S)? ☐ Yes ☐ No

CLINICAL INFORMATION

Diagnosis date: _____________

Was patient jaundiced? ☐ Yes ☐ No ☐ Unknown
If Yes, start date: _____________

Did patient have symptoms other than jaundice?
☐ Yes ☐ No ☐ Unknown If Yes, onset date: ___________

What symptoms?
☐ Abdominal Pain ☐ Dark Urine ☐ Diarrhea
☐ Anorexia ☐ Clay stools ☐ Fever
☐ Headache ☐ Nausea ☐ Vomiting
☐ Fatigue ☐ Malaise ☐ Myalgia
☐ Joint pain ☐ Other (specify): __________________

Did the patient visit the emergency room for illness? ☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized for hepatitis?
☐ Yes ☐ No ☐ Unknown If Yes, add hospitalization details

Medical Record Number

Facility/Hospital Name:

Admit date	Discharge date	Did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? ☐ Yes ☐ No ☐ Unknown

If female: Pregnant? ☐ Yes ☐ No ☐ Unknown If Yes, due date: _____________

Did the patient develop fulminant hepatitis? ☐ Yes ☐ No ☐ Unknown

Did the patient die from hepatitis? ☐ Yes ☐ No ☐ Unknown If Yes, date of death: ___________

VACCINE HISTORY *Look up case in CAIR and/or review other immunization records and indicate whether they received the 2 dose or 3 dose vaccine series.*

	Yes	No	Unk	If Yes, vaccine type/name	2 or 3 dose series?	1st Dose Date	2nd Dose Date	3rd Dose Date
Hepatitis A vaccine	☐	☐	☐		2 ☐ 3 ☐			
Hepatitis B vaccine	☐	☐	☐		2 ☐ 3 ☐			

If ≤18 Years and not vaccinated, specify why not vaccinated: ____

Reason for testing: (check all that apply)
☐ Symptoms of acute hepatitis
☐ Evaluation of abnormal liver biochemistries/liver function tests
☐ Exposure to case
☐ Routine screening of patient (physical exam, MD visit, pre-op)
☐ Blood/organ donor screening
☐ Prenatal screening
☐ Unknown
☐ Other (specify): ____

LABORATORY INFORMATION *(Check all tests performed and attach laboratory results.)*

Hepatitis A Diagnostic Tests	Positive	Negative	Borderline	Not Tested	Unknown	Specimen Collection Date
Total antibody to hepatitis A virus (total anti-HAV) ………………….....	☐	☐	☐	☐	☐	__________________
IgM antibody to hepatitis A virus (IgM anti-HAV) ………………..…….	☐	☐	☐	☐	☐	__________________
Hepatitis A virus PCR (HAV PCR) ……………..…………….…...…….	☐	☐	☐	☐	☐	__________________

HAV genotype _________________

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Patient Name (Last, First) ____________________ Date of Birth ____________ IRIS ID: __________

LABORATORY INFORMATION – Continued *(Check all tests performed and attach laboratory results.)*

Hepatitis B Diagnostic Tests	Positive	Negative	Borderline	Not Tested	Unknown	Specimen Collection Date
Total antibody to hepatitis B core antigen (total anti-HBc) …………......	☐	☐	☐	☐	☐	__________
IgM antibody to hepatitis B core antigen (IgM anti-HBc) ………………	☐	☐	☐	☐	☐	__________
Hepatitis B surface antigen (HBsAg) ……………………………………	☐	☐	☐	☐	☐	__________
Antibody to hepatitis B surface antigen (anti-HBs) ……………………	☐	☐	☐	☐	☐	__________
Hepatitis B e antigen (HBeAg) ……………………………………...	☐	☐	☐	☐	☐	__________
Antibody to hepatitis B e antigen (anti-HBe) ……………………………	☐	☐	☐	☐	☐	__________
Hepatitis B Nucleic Acid Test (NAT) (HBV DNA) …………….……….	☐	☐	☐	☐	☐	__________
Hepatitis C Diagnostic Tests						
Antibody to hepatitis C virus (anti-HCV) ………………………………..	☐	☐	☐	☐	☐	__________
Hepatitis C Nucleic Acid Test (NAT) (HCV RNA) …..……………….....	☐	☐	☐	☐	☐	__________
HCV genotype ______________						
Other Viral Hepatitis Diagnostic Tests						
Antibody to hepatitis D virus (IgM anti-HDV) …………………………..	☐	☐	☐	☐	☐	__________
Hepatitis D Nucleic Acid Test (NAT) (HDV RNA) …………..…………	☐	☐	☐	☐	☐	__________
Antibody to hepatitis E virus (IgM anti-HEV) …………………………..	☐	☐	☐	☐	☐	__________
Hepatitis E Nucleic Acid Test (NAT) (HEV RNA) ……………..……….	☐	☐	☐	☐	☐	__________

Liver enzyme results at time of diagnosis:

Specimen collection date: __________ ALT (SGPT) ________ AST (SGOT) ________ Total Bilirubin ________

Peak liver enzyme results:

ALT (SGPT) ________ Specimen collection date: __________ AST (SGOT) ________ Specimen collection date: __________

Total Bilirubin ________ Specimen collection date: __________

PUBLIC HEALTH NURSING INITIAL ASSESSMENT AND EVALUATION

If acute hepatitis (check here ☐), please complete the remainder of this form. See Page 5 for acute hepatitis B definition.
If **NOT** acute hepatitis (check here ☐), please go to **Final Diagnosis** section and complete.

INFECTION TIMELINE

Incubation period: 60-150 days, average 90 days.
Infectious period: Transmission can occur any time that HBsAg is present in the blood.
Post-exposure prophylaxis: See B-73.

If symptomatic, enter date of onset* in onset box. If asymptomatic, enter specimen collection date of first positive test in onset box. Count backward to determine probable exposure period.

EXPOSURE PERIOD

	-150 days	-60 days	ONSET*
Days from onset:			
Calendar dates: *(month/day/year)*	________	________	________

*onset of jaundice or onset of symptoms if not jaundiced

CLOSE CONTACTS (e.g., household and sexual contacts, persons using injection or non-injection drugs with the HBV-infected person)

Name/ Relationship to case	Age	Prior history of Hepatitis B vaccine?			If not fully vaccinated, Hepatitis B vaccine given?			Date vaccine given	Comments (include Prophylaxis and/or Vaccine)
		Yes	No	Unk	Yes	No	Unk		
		☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐		
		☐	☐	☐	☐	☐	☐		

Patient Name (Last, First) ____ Date of Birth _________________ IRIS ID: ____________

EPIDEMIOLOGIC RISK FACTORS *(Refer to Infection Timeline above)*

During the INCUBATION PERIOD: If YES, ask patient when and record additional details in Remarks section.

	Yes	No	Unk
Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?	☐	☐	☐
If Yes, contact type: ☐ Sexual ☐ Household (Non-sexual) ☐ Injection drug use ☐ Occupation ☐ Other: ________________			
Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?	☐	☐	☐
If Yes, date: _______________			
Did the patient have other exposure to someone else's blood?	☐	☐	☐
If Yes, date: _______________			

During the INCUBATION PERIOD: If any treatments/procedures in healthcare facilities, indicate dates & facility details below.

	Yes	No	Unk
Did the patient receive blood or blood products (transfusion)?	☐	☐	☐
Did the patient receive an organ (transplant)?	☐	☐	☐
Did the patient undergo hemodialysis?	☐	☐	☐
Did the patient have prior history of hospitalization?	☐	☐	☐
Did the patient have any outpatient medical procedure or surgery (e.g. colonoscopy, endoscopy)?	☐	☐	☐
Did the patient receive any IV infusions and/or injections prescribed by a doctor?	☐	☐	☐
Did the patient have dental work or oral surgery?	☐	☐	☐
Did the patient have surgery other than oral surgery?	☐	☐	☐
Did the patient receive fingersticks or blood draw in home or clinic?	☐	☐	☐
Did the patient have any podiatric procedures?	☐	☐	☐
Did the patient receive chemotherapy treatment?	☐	☐	☐
Did the patient undergo acupuncture?	☐	☐	☐
Was the patient a resident of a long-term facility (e.g. nursing home)?	☐	☐	☐

If only risk factors are healthcare treatments/procedures, notify ACDC about potential healthcare acquired infection.

During the INCUBATION PERIOD: If any procedures in other exposure sites, indicate dates & details below.

	Yes	No	Unk
Did the patient have any part of their body pierced (other than ear)?	☐	☐	☐
If Yes, where was the piercing performed? ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other: ________________			
Did the patient receive a tattoo?	☐	☐	☐
If Yes, where was the tattooing performed? ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other: ________________			
Did the patient have a manicure or pedicure?	☐	☐	☐
Did the patient have any other treatment or cosmetic procedure that penetrated the skin (e.g. head or neck shave)?	☐	☐	☐

If Yes, specify ____

FACILITY OR OTHER POSSIBLE EXPOSURE SITE DETAILS

Facility/Site Name	Facility/Site Type (clinic, hospital, etc.)	Facility/Site Location (address, location, phone #)	Date of 1st procedure Or seen at facility/site	Date last seen at facility/site	Description of procedure/ exposure

	Yes	No	Unk
Did the patient inject drugs not prescribed by a doctor?	☐	☐	☐
Did the patient use street drugs but not inject?	☐	☐	☐

Drug Name	Route of Administration (e.g.: smoked, snorted, injected, taken by mouth)

	Yes	No	Unk
Was the patient incarcerated for longer than 24 hours?	☐	☐	☐

If Yes, what type of facility (check all that apply): ☐ Prison ☐ Jail ☐ Juvenile facility

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EPIDEMIOLOGIC RISK FACTORS – Continued *(Refer to Infection Timeline above)*

During the INCUBATION PERIOD: If YES, ask patient when and record additional details in Remarks section.

Question	Yes	No	Unk
Was the patient experiencing homelessness/unstable housing?	☐	☐	☐

How many sex partners did the patient have? (Ask questions regardless of the patient's gender.)

Number of male sex partners: __________ ☐ Unknown ☐ Refused to answer

Number of female sex partners: __________ ☐ Unknown ☐ Refused to answer

Number of trans/non-binary sex partners: __________ ☐ Unknown ☐ Refused to answer

Question	Yes	No	Unk
Was the patient EVER treated for a sexually transmitted disease?	☐	☐	☐
Was the patient EVER denied from donating blood due to hepatitis infection?	☐	☐	☐
Did the patient donate blood?	☐	☐	☐

Date of last blood donation: ____________ Location of last donation: ______________________________

Question	Yes	No	Unk
Did the patient travel outside of the United States?	☐	☐	☐

If Yes, specify location(s) and dates of travel?

Travel Locations (city, county, state, country)	Dates of Travel	
	From	To

Question	Yes	No	Unk
Was the patient employed in a medical or dental field involving direct contact with human blood?	☐	☐	☐
Was the patient employed as a public safety worker (firefighter, law enforcement/correctional officer) having direct contact with human blood?	☐	☐	☐

Indication of recent seroconversion

Question	Yes	No	Unk
Negative HBsAg result within 12 months prior to HBV diagnosis	☐	☐	☐

If Yes, collection date: ____________

Question	Yes	No	Unk
Was the patient epi-linked to known case?	☐	☐	☐

If Yes, Contact Name/Case #: ______________________________

Question	Yes	No	Unk
Was the patient a part of known outbreak?	☐	☐	☐

If Yes, extent of outbreak: ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other: ______________________

REMARKS *(Please explain any YES answers in Epidemiologic Risk Factor section. Please sign your notes.)*

Suspected Source

Educated patient according to B-73 on the following:

Mode of Transmission:
- ☐ Blood to Blood
- ☐ Sexual
- ☐ Maternal Infant Transmission

Prevention:
- ☐ Household Contacts
- ☐ Vaccine
- ☐ Personal Hygiene
- ☐ Immunoglobulin (HBIG)

Other:

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Patient Name (Last, First) ____________________ Date of Birth ____________ IRIS ID: ________

FINAL DIAGNOSIS

☐ Acute Hepatitis B:

☐ Confirmed

☐ Probable

☐ Chronic Hepatitis B

☐ Not acute or chronic hepatitis B (False)

☐ Acute Hepatitis D

☐ Chronic Hepatitis D

☐ Unable to locate (UTL)

☐ Could not confirm: Why? ____________________

Does this case meet the binational case definition?

☐ Yes ☐ No ☐ Unknown

Binational Case Definition:
Any individual with a confirmed or probable case of a notifiable infectious disease, and:

1) Who has recently traveled or lived in Mexico, or had recent contact with persons who lived or traveled in Mexico; **OR**
2) Who is thought to have acquired the infection in Mexico or have been in Mexico during the incubation period of the infection and was possibly contagious during this period; **OR**
3) Who is thought to have acquired the infection from a product from Mexico; **OR**
4) Whose case requires the collaboration of both countries for the purposes of disease investigation and control.

Acute Hepatitis B Case Definition:

Confirmed Acute:

Must have the following:

1) Detection of IgM anti-HBc
2) Detection of HBsAg **OR** HBeAg **OR** HBV DNA

OR

HBsAg seroconversion: Detection of HBsAg **OR** HBeAg **OR** HBV DNA within 12 months (365 days) of a negative HBsAg test result.

Probable Acute:

Must have the following:

1) Detection of IgM anti-HBc
2) Negative or not done for HBsAg, HBV DNA, or HBeAg
3) Acute onset or new detection of Jaundice **OR** Total bilirubin ≥ 3.0mg/dL **OR** ALT levels > 200 IU/L
4) Absence of a more likely diagnosis

Investigator's name (print)	Investigator's signature	Date	Telephone number
Health District	Supervisor signature	Area Medical Director's signature	