The information requested on this form is required by the California Department of Public Health for purposes of identification and public health investigation.

ACUTE HEPATITIS B CASE REPORT FORM

Included below are the acceptable submission methods of this form:

- **Healthcare Providers:** Please submit this form to your local health department.
- **Local Health Jurisdictions:** Please enter this form into CalREDIE and upload a copy into the CalREDIE Electronic Filing Cabinet or send via fax to (510) 620-3949 or secure email to vpdreport@cdph.ca.gov

PATIENT INFORMATION

Last Name: ______________________ **First Name:** ______________________ **Middle Name:** ___________________ **Suffix:** __________

Date of Birth: _____________________ **Age (enter and check one):** ________ ☐ Days ☐ Weeks ☐ Months ☐ Years

Patient's Parent/Guardian Name: _________________________ **Primary Language:** ☐ English ☐ Other: __________________________

Address Number & Street: ____ **Apartment/Unit Number:** ________________________

City: ________________________ **State:** ________ **Zip Code:** ____________ **County of Residence:** _______________________________

Country of Residence: ☐ U.S. ☐ Other: _________________________ **Country of Birth:** ☐ U.S. ☐ Other: _________________________

Date of Arrival: ________________ **Home Telephone:** (_____) ________________ **Cellular Phone/Pager:** (_____) _________________

Email Address: __________________________________ **Other Electronic Communication:** _______________________________________

Work/School Location (Name & Address): ____

Occupation Setting: ☐ Correctional Facility ☐ Hospital/Medical/Dental ☐ Public Safety ☐ Long Term Care Facility ☐ Unknown ☐ Other: ____

Specify Occupation: ____ **Work/School Telephone:** (_____) ___________________

Gender: ☐ Declined to answer ☐ Female ☐ Genderqueer or non-binary ☐ Identity not listed ☐ Male ☐ Trans female/Transwoman ☐ Trans male/Transman ☐ Unknown

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Declined to Answer ☐ Unknown

Sexual Orientation: ☐ Heterosexual or straight ☐ Gay, lesbian, or same-gender loving ☐ Bisexual ☐ Orientation not listed ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer ☐ Unknown

Pregnant: ☐ Yes ☐ No ☐ Unknown **Estimated Delivery Date:** _______________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race (check all that apply):

☐ American Indian or Alaska Native

☐ Asian

☐ Asian-Burmese ☐ Bangladeshi ☐ Bhutanese ☐ Burmese ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong
☐ Indian ☐ Indonesian ☐ Iwo Jiman ☐ Japanese ☐ Korean ☐ Laotian ☐ Madagascar ☐ Malaysian
☐ Maldivian ☐ Nepalese ☐ Okinawan ☐ Pakistani ☐ Singaporean ☐ Sri Lankan ☐ Taiwanese ☐ Thai
☐ Vietnamese ☐ Unknown ☐ Other: ___________________________________

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ Carolinian ☐ Chamorro ☐ Chuukese ☐ Fijian ☐ Guamanian ☐ Kiribati ☐ Kosraean ☐ Mariana Islander
☐ Marshallese ☐ Melanesian ☐ Micronesian ☐ Native Hawaiian ☐ New Hebrides ☐ Palauan ☐ Papua New Guinean
☐ Pohnpeian ☐ Polynesian ☐ Saipanese ☐ Samoan ☐ Soloman Islander ☐ Tahitian ☐ Tokelauan ☐ Tongan
☐ Yapese ☐ Unknown ☐ Other: ___________________________________

☐ White

☐ Other: ___________________________________

☐ Unknown:

CLINICAL INFORMATION

REASON FOR TESTING

Reasons (check all that apply)

☐ Blood/Organ Donor Screening ☐ Evaluation of Liver Enzymes ☐ Exposure to Case ☐ Prenatal Screening ☐ Routine Testing
☐ Symptoms of Acute Hepatitis ☐ Unknown ☐ Other: ____________________________

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown

Symptoms? ☐ Abdominal Pain ☐ Anorexia ☐ Clay Stools ☐ Dark Urine ☐ Diarrhea ☐ Fatigue ☐ Jaundice [Onset Date: ___________]
☐ Other: ______________________________________

HOSPITALIZATION AND HOSPITAL DETAILS

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

Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown **How many total hospital nights?** _____________

During any part of the hospitalization, did patient stay in an intensive care unit or critical care unit? ☐ Yes ☐ No ☐ Unknown

Hospital Name: ____ **Street Address:** ____

City: ___________________________ **State:** __________ **Zip Code:** ________________ **Telephone:** (_____) ________________

Admit Date: _______________ **Discharge/Transfer Date**: ________________ **Medical Record Number:** _____________________

Discharge Diagnosis: ____

COMPLICATIONS AND OTHER SYMPTOMS

Did patient die? ☐ Yes ☐ No ☐ Lost to Follow-Up **Date of Death:** ________________

VACCINATION HISTORY

Hepatitis B Vaccination History

Has the patient been immunized for hepatis B? ☐ Yes ☐ No ☐ Unknown **Vaccine Type:** _____________________________________

If ≤ 18 Years, specify why not vaccinated? ____

Hepatitis A Vaccination History

Has the patient been immunized for hepatis A? ☐ Yes ☐ No ☐ Unknown **Vaccine Type**: _____________________________________

LABORATORY INFORMATION

VIRAL HEPATITIS B DIAGNOSTIC TESTS

Hepatitis B Surface Antigen (HBsAg)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

IgM Antibody to Hepatitis B Core Antigen (IgM anti-HBc)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

Antibody to Hepatitis B Surface Antigen (Anti-HBs)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

Total Antibody to Hepatitis B Core Antigen (Anti-HBc total)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

Quantitative Hepatitis B DNA (HBV DNA Quant.)

Date: _____________ Result (IU/ml): _____________________

Qualitative Hepatitis B DNA (HBV DNA Qual.)

Date: _____________ Result: ☐ Detected ☐ Not Detected ☐ Pending ☐ Not Done ☐ Unknown

Hepatitis B Envelope Antigen (HBeAG)

Date: _____________ Result: ☐ Detected ☐ Not Detected ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

VIRAL HEPATITIS A DIAGNOSTIC TESTS

IgM Antibody to Hepatitis A Virus (IgM anti-HAV)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

Total Antibody to Hepatitis A Virus (Anti-HAV Total)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Borderline

VIRAL HEPATITIS C DIAGNOSTIC TESTS

Hepatitis C Antibody (Anti-HCV)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown

Hepatitis C Ribonucleic Acid (HCV RNA)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown

Specify HCV Genotype (if available): ___________________________

VIRAL HEPATITIS D DIAGNOSTIC TESTS

Antibody to Hepatitis Delta (Anti-HDV)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown

VIRAL HEPATITIS E DIAGNOSTIC TESTS

Antibody to Hepatitis E (Anti-HEV)

Date: _____________ Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown

LIVER ENZYME LEVELS AT DIAGNOSIS

Alaine Transaminase [Serum Glutamic Pyruvic Transaminase] (ALT [SGPT])

Date: _____________ Result: ______________________ Upper Limit Normal: ______________________

Aspartate Aminotransferase [Serum Glutamic Oxaloacetic Transaminase] (AST [SGOT])

Date: _____________ Result: ______________________ Upper Limit Normal: ______________________

Bilirubin

Date: _____________ Result: ______________________

EPIDEMIOLOGICAL INFORMATION

INCUBATION PERIOD

- Hepatitis B: range 60 to 150 days, average 90 days.
- Incubation Period: ________________ to ________________

RISK FACTOR INFORMATION

During the incubation period, were any of the following risk factors present?	Yes	No	Unknown	Date
Contact with a confirmed or suspected case of hepatitis B	☐	☐	☐	______________
If yes, type of contact: ☐ Household ☐ Sexual ☐ Injection ☐ Occupational ☐ Other: ______________________				
Accidental stick/puncture with an object contaminated with blood	☐	☐	☐	______________
Other exposure to someone's blood	☐	☐	☐	______________

During the incubation period, did the patient have any of the following treatment or cosmetic procedures?	Yes	No	Unknown	Date first seen at facility	Date last seen at facility	Facility Name
Receipt of blood or blood products (transfusion)	☐	☐	☐	____________	____________	________________
Receipt of organ (transplant)	☐	☐	☐	____________	____________	________________
Hemodialysis	☐	☐	☐	____________	____________	________________
Prior hospitalization	☐	☐	☐	____________	____________	________________
Received outpatient procedure (i.e., colonoscopy, endoscopy)	☐	☐	☐	____________	____________	________________
Received injection or infusions prescribed by a doctor	☐	☐	☐	____________	____________	________________
Oral surgery or dental work	☐	☐	☐	____________	____________	________________
Surgery other than oral surgery	☐	☐	☐	____________	____________	________________
Fingerstick or blood draw in home or clinic	☐	☐	☐	____________	____________	________________
Podiatric procedures	☐	☐	☐	____________	____________	________________
Chemotherapy treatment	☐	☐	☐	____________	____________	________________
Acupuncture treatment	☐	☐	☐	____________	____________	________________
Body Piercing	☐	☐	☐	____________	____________	________________

If yes, where was piercing performed? ☐ Commercial Parlor ☐ Jail or Prison ☐ Other: ____________________

Tattoo	☐	☐	☐	________	________	____________
If yes, where was tattoo received? ☐ Commercial Parlor ☐ Jail or Prison ☐ Other: ____________________						
Manicure or pedicure	☐	☐	☐	________	________	____________
Other treatment or cosmetic procedure that penetrated the skin (e.g. head or neck shave) If yes, specify: ____________________	☐	☐	☐	________	________	____________

During the incubation period, were any of the following applicable to the patient?	Yes	No	Unknown
Injection drug use not prescribed by a doctor	☐	☐	☐
Used non-injection street drugs	☐	☐	☐
Was incarcerated	☐	☐	☐
One or more male sex partners Number of male partners ____________	☐	☐	☐
One or more female sex partners Number of female partners ____________	☐	☐	☐
One or more trans/non-binary sex partners? Number of trans/non-binary partners ____________	☐	☐	☐
Ever treated for a sexually-transmitted infection	☐	☐	☐
Ever donated blood (or was denied due to hepatitis infection) If yes, specify year and location of last blood donation ____________________	☐	☐	☐
Homelessness/unstable housing	☐	☐	☐
Negative HBsAg result within 6 months prior to HBV diagnosis If yes, collection date ____________	☐	☐	☐
Indication of recent seroconversion (see seroconversion definition on bottom of page 4)	☐	☐	☐

EPIDEMIOLOGICAL LINKAGE

Epi-Linked to known case? ☐ Yes ☐ No ☐ Unknown **Contact Name/Case #:** ____________________

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unknown

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

Mode of Transmission ☐ Point Source ☐ Person-to-Person ☐ Unknown ☐ Other: ____________________

CASE DEFINITION

☐ **CONFIRMED ACUTE HEPATITIS B**: Acute illness with discrete symptom onset and at least one item each from columns I, II, and III and is not known to have chronic hepatitis B infection

I	II	III
• Jaundice • ALT >100IU/L	• HBsAg positive	• IgM anti-HBc positive (if done)

☐ **HEPATITIS B SEROCONVERSION:** Negative HBsAg result with a positive HBV result (either HBsAg, HBeAg, HBV DNA, or HBV genotype) in the following 6 months; may be asymptomatic.

BINATIONAL CASE INVESTIGATION

Binational Case Definition

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

- who has recently traveled or lived in Mexico, or had recent contact with persons who lived or traveled in Mexico; or
- 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
- who is thought to have acquired the infection from a product from Mexico; or
- whose case requires the collaboration of both countries for the purposes of disease investigation and control.

Does this case meet the binational case definition? ☐ Yes ☐ No ☐ Unknown

NOTES

CASE INVESTIGATION

Completed by: ____ **Local Health Jurisdiction:** ______________________________________

Telephone: (_____) ________________ **Date Completed:** __________________ **Date Reported:** __________________