Hepatitis B - Perinatal

County

Case name (last, first) ______________________
Birth date ___/___/___ Alternate name ______________________
Phone ______________________ Email ______________________
Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work
Street address ______________________
City/State/Zip/County ______________________
Residence type (incl. Homeless) ______________________ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

☐ Hepatitis D co-infected
LHJ notification date ___/___/___ **Investigator**________________ **Investigation start date** ___/___/___

LHJ Classification ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ State case ☐ Contact ☐ Control ☐ Exposure ☐ Not classified

Investigation status ☐ Investigation not started ☐ In progress ☐ Complete ☐ Complete - not reportable to DOH ☐ Unable to complete
Investigation complete date ___/___/___ **LHJ record complete date** ___/___/___ (enter at the end)
Outbreak related ☐ Yes ☐ No **LHJ Cluster Name** _____________ **LHJ Cluster ID** ________

REPORT SOURCE(S)

Report source ______________________ Report date ___/___/___
Reporter name ______________________ Reporter organization ______________________
Reporter phone ______________________

DEMOGRAPHICS: Refers to Child ≤24 Months of Age

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?
Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):
Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American ☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Country of birth (your child): ______________________

Additional race information:
☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: ______________

What is your (your childs) preferred language? Check one:
☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: ______________ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

COMMUNICATIONS

OK to talk to patient? (Refers to guardian for infant.) ☐ Yes ☐ Later ☐ Never ☐ Unk

Contact attempted ☐ Yes ☐ No

Contact attempt type:
☐ Phone call to patient ☐ Phone call to medical provider ☐ Medical record search (electronic or hardcopy)
☐ Text to patient ☐ Letter to patient ☐ E-mail to patient ☐ Patient's social media
☐ Other contact attempt type ___________________________________

Contact attempt outcome:
☐ Unable to contact ☐ Contacted and interviewed ☐ Contacted and scheduled ☐ Successful medical record review
☐ Left message ☐ Pending response ☐ Reinterviewed

If contact attempted, fill in date and interviewer.
Date ___/___/___ Interviewer _______________ Interviewer's jurisdiction _______________

Was patient acute, chronic or perinatal at the time of contact attempt? ☐ Acute ☐ Chronic ☐ Perinatal ☐ Unknown

Alternate contact ☐ Friend ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other (describe) ____________________
Contact name ________________________________ Contact phone _______________________________

CLINICAL EVALUATION

Maternal Information
Delivery hospital _______________________________________

Y N DK NA
☐ ☐ ☐ ☐ **Birth mother confirmed HBsAg positive prior to or at time of delivery**
☐ ☐ ☐ ☐ **Birth mother confirmed HBsAg positive after delivery**
☐ ☐ ☐ ☐ **Birth mother confirmed Hepatitis B e antigen (HBeAg) positive**

Y N DK NA
☐ ☐ ☐ ☐ Birth mother born outside of USA Country ___________________________________
☐ ☐ ☐ ☐ Birth mother race or ethnicity known
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply) ☐ Amer Ind/AK Native ☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other ___________________________________

Onset and Diagnosis
Symptom onset date ___/___/___ *Enter date of testing as onset date*

Infant had symptoms of acute hepatitis? ☐ Yes ☐ No ☐ Unk
Perinatal diagnosis date ___/___/___

Infant Vaccination History
Washington Immunization Information System (WA IIS) number ____________________
Received HBIG? ☐ Yes ☐ No ☐ Unk
Date HBIG received ___/___/___
Timing of HBIG ☐ 0-12 hours after birth ☐ 13-24 hours after birth ☐ 1-7 days after birth ☐ >7 days after birth
☐ Unknown
Received hepatitis B containing vaccine? ☐ Yes ☐ No ☐ Unk
Number of doses _______
Date of vaccine administration #1 ___/___/___
Vaccine administered (type) ☐ Single antigen HBV ☐ HBV combination
Vaccine brand name __________________________
Vaccine lot number ___________________________
Vaccine manufacturer _________________________
Administering provider _________________________
Information source ☐ WA IIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date
☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration #2 ___/___/___

Vaccine administered (type) ☐ Single antigen HBV ☐ HBV combination

Vaccine brand name ___________________________

Vaccine lot number ____________________________

Vaccine manufacturer __________________________

Administering provider __________________________

Information source ☐ WA IIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration #3 ___/___/___

Vaccine administered (type) ☐ Single antigen HBV ☐ HBV combination

Vaccine brand name ___________________________

Vaccine lot number ____________________________

Vaccine manufacturer __________________________

Administering provider __________________________

Information source ☐ WA IIS ☐ Medical record ☐ Patient vaccination card ☐ Verbal with approximate date ☐ Verbal only/no documentation ☐ Other state IIS

Insurance

Insurance status date ___/___/___

Death

If deceased, please change the vital status and update date of death on the Edit Person screen

Vital Status ☐ Dead ☐ Alive

Death date ___/___/___

Source used to verify vital status ☐ Death records ☐ Medical records ☐ Other _________________________________

Laboratory Diagnostics (Positive, Negative, Not tested, Indeterminate)

Enter all laboratory results in the Investigation Template/Lab Tab.

(Positive, Negative, Not tested, Indeterminate)

P N NT I

☐ ☐ ☐ ☐ **Hepatitis B surface antigen (HBsAg)**

Specimen collection date ___/___/___ Specimen accession # ___________________________

Test laboratory _________________________________ Test provider/facility _____________________________

☐ ☐ ☐ ☐ **Hepatitis B e antigen (HBeAg)**

Specimen collection date ___/___/___ Specimen accession # ___________________________

Test laboratory _________________________________ Test provider/facility _____________________________

☐ ☐ ☐ ☐ **IgM antibody to hepatitis B core antigen (IgM anti-HBc)**

Specimen collection date ___/___/___ Specimen accession # ___________________________

Test laboratory _________________________________ Test provider/facility _____________________________

☐ ☐ ☐ ☐ **HBV DNA quantitative** _________ Quantitative units ☐ I.U. ☐ I.U., log ☐ DNA copies ☐ DNA copies, log

Qualitative interpretation of quantitative result

Specimen collection date ___/___/___ Specimen accession # ___________________________

Test laboratory _________________________________ Test provider/facility _____________________________

☐ ☐ ☐ ☐ **HBV DNA qualitative**

Specimen collection date ___/___/___ Specimen accession # ___________________________

Test laboratory _________________________________ Test provider/facility _____________________________

☐ ☐ ☐ ☐ **HBV genotype** _______

Specimen collection date ___/___/___ Specimen accession # ___________________________

Test laboratory _________________________________ Test provider/facility _____________________________

Liver Enzyme Tests

☐ ALT (SGPT) Specimen collection date ___/___/___ Actual value _______

☐ AST (SGOT) Specimen collection date ___/___/___ Actual value _______

PUBLIC HEALTH ISSUES AND ACTIONS

Y N Unk

☐ ☐ ☐ Failure of vaccine or post-exposure prophylaxis

☐ ☐ ☐ Counseled parents about importance of Hep A and Hep B vaccines

☐ ☐ ☐ Counseled parents on importance of regular healthcare to monitor liver health

NOTES

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.