

For reporting of Viral Hepatitis Cases among New York State Department of Corrections Inmates ONLY.
Do not use for County Jail Inmates. Please complete and fax or mail to the appropriate Local Health Department.
Questions? Call: New York State Department of Health, Bureau of Communicable Disease Control, Hepatitis Unit at 518.473.4439

Facility Information: Inmate's Current Facility Name: _____ County: _____
Reporting Individual: _____ Phone: _____ Date: ____/____/____

Inmate Information

Name: _____ DOB: ____/____/____
Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
Race: White Black American Indian/Alaska Native Asian
 Native Hawaiian/Pacific Islander Other, specify: _____ Unknown
Sex: Male Female Pregnant: Yes No Unknown
Inmate Country of Birth: _____ DIN Number: _____ County of Commitment: _____
Please verify diagnosis (*refer to case definitions*): Acute Chronic

Clinical Information/Diagnostic Tests

Is the patient symptomatic? Yes No If yes, onset date: ____/____/____
Is the patient jaundiced? Yes No If yes, onset date: ____/____/____
HBsAg Positive Negative Date: ____/____/____
IgM anti-HBc Positive Negative Date: ____/____/____
HBV DNA Positive Negative Date: ____/____/____
Other tests/results: _____ Date: ____/____/____
ALT (SGPT): _____ Date: ____/____/____ AST (SGOT): _____ Date: ____/____/____

Lifetime Risk Factors for HBV (Chronic Only)

	YES	NO	UNKNOWN
Ever on long term hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever injected drugs, even if only once or a few times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple lifetime sex partners? If yes, approximate #: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever treated for STDs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever a contact of a person who had hepatitis B virus? If yes, type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household (non-sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever work in a medical/dental field involving direct contact with human blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever have a needlestick exposure (occupational)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a body piercing (not including ear piercing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Copy to inmate medical record.