

[County Letterhead]

Dear Doctor:

The _____ Health Department has received a positive hepatitis B virus (HBV) laboratory result for your patient, _____. New York State Public Health Law mandates that laboratories and physicians report cases of hepatitis A, B, and C to county health department in which the patient resides.

Please complete the attached form as completely as possible. If the patient is an acute case, please call us at _____ immediately so that we may identify the source of the new infection and evaluate the need for immunoprophylaxis for close contacts of the patient.

For chronic cases, please return the form by mail or fax within 21 days to the _____ County Health Department at the address listed below or fax to _____

Mailing address:

X County Health Department

CD Staff Name

Address

Thank you for your assistance.

Please note the following case definitions when verifying the patient diagnosis:

Acute Hepatitis B (CSTE/CDC Revised 2000)

Clinical Criteria:

Acute illness with:

- discrete onset of symptoms (e.g., fatigue, abdominal pain, loss of appetite, intermittent nausea, vomiting), and
- jaundice or elevated serum aminotransferase (ALT) levels

AND

Laboratory Criteria:

- IgM anti-HAV negative (if done), and
- IgM anti-HBc positive or HBsAg positive

Chronic Hepatitis B (CDC/CSTE 2007)

Clinical Criteria:

- Persons with chronic 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. Persons with chronic infection may be asymptomatic.

Laboratory Criteria:

- IgM anti-HBc negative, and
- Positive result for one of the following tests: HBsAg, HBeAg, or HBV Nucleic Acid Test (NAT)

OR

- HBsAg positive or HBV NAT positive, or HBeAg positive two times at least 6 months apart (any combination of these tests performed 6 months apart is acceptable).

CONFIDENTIAL

Follow-up of Positive Hepatitis B Laboratory Report

Provider Information: Ordering Provider:

Primary Care Provider, if known: _____ **Phone:** _____

Patient Information Please provide any missing patient demographic information

Last Name: _____ **First Name** _____ **Address:** _____

City: _____ **Zip:** _____ **DOB:** _____

Please circle appropriate values

Occupation: Food service Day care Health care Student/School Inmate Correction work
Other, specify _____ Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: White Black American Indian/Alaskan Asian Native Hawaiian/Other Pacific Islander
Other, Specify _____ Unknown

Sex: Male Female

Is patient pregnant: Yes **Due Date:** __/__/__ No Unknown

Please verify diagnosis (refer to case definitions): Acute* Chronic Not a Case

*PLEASE CALL THE LOCAL HEALTH DEPARTMENT IMMEDIATELY (Contact information is on the cover letter)

Was the patient provided education/counseling regarding hepatitis B infection? Yes No

Reasons for HBV Testing Check all that apply

- Symptoms of acute viral hepatitis
- Evaluation of elevated liver enzymes
- Screening of an asymptomatic patient with reported risk factors
- Blood/organ donor screening
- Screening of an asymptomatic patient with no reported risk factors
- Follow-up testing for previous marker of viral hepatitis
- Prenatal screening
- Other, specify _____

Clinical Information/Diagnostic Tests

Was the patient symptomatic? Yes No Unknown if yes, onset date __/__/__

Was the patient jaundiced? Yes No Unknown if yes, onset date __/__/__

Was the patient hospitalized? Yes No Unknown if yes, admit date __/__/__
hospital _____

Did patient die from hepatitis? Yes No Unknown if yes, date of death __/__/__

ALT(SGPT) _____ Date __/__/__

AST(SGOT) _____ Date __/__/__

Other Tests/Results _____ Date __/__/__

Other Tests/Results _____ Date __/__/__

Did the patient have prior negative hepatitis B surface antigen (HBsAg) test results? Yes No Unknown

If yes, date of collection __/__/__

Risk Factors for HBV (Chronic Only)

Birth Country _____

Long-term hemodialysis Yes No Unknown Employed in medical/dental field Yes No Unknown

Injection drug use Yes No Unknown Needlestick exposure Yes No Unknown

Multiple lifetime sexual partners Yes No Unknown Tattoo Yes No Unknown

If yes, approx. no. (lifetime): _____

Ever treated for a STD Yes No Unknown Body piercing Yes No Unknown

Ever incarcerated Yes No Unknown Other, specify: _____ Yes No Unknown

Contact of person with hepatitis B

- Sexual Yes No Unknown

- Household Yes No Unknown

- Other _____ Yes No Unknown

Vaccine History

Did the patient ever receive hepatitis B vaccine? Yes No Unknown

If yes, how many doses? _____

In what year was the last dose received? _____

Was the patient tested for antibody to HBsAg (anti-HBs within 1-2 months after the last dose)? Yes No Unknown

If yes, was the serum anti-HBs >= 10 IU/ml (answer yes if the lab result was reported as positive or reactive)? Yes No Unknown

Did the patient receive hepatitis A vaccine? Yes No Unknown

If no, please select why Not Offered Refused Immune due to history of HAV Previously vaccinated

Individual completing form: _____ **Title:** _____ **Date:** _____

Laboratory Results

| Test Type: | Specimen Collection Date: | Test Result: |
|------------|---------------------------|--------------|
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