

Revised: 06/23/2011

Patient Name: _____ Date of Birth: ____/____/____ Serial Number: _____

**New York State Department of Health
Hepatitis B Acute Supplemental**

General Instructions: All suspected acute hepatitis B cases should be followed-up, beginning with clinical information obtained from the provider. Please note that this form serves multiple purposes: the questions are designed to determine whether or not the patient is truly a case of hepatitis B infection, the patient’s source of infection and appropriate control measures. Once a diagnosis can be confirmed, patients must be interviewed to complete the remainder of the form. Please attempt to complete this form in its entirety, and accurately to maintain data quality. **Please do not respond “unknown”** to any questions unless the patient reports that they do not know the answer to the question. If the case meets CSTE case definition, the information gathered from providers and patients should be reported electronically via CDESS.

PATIENT INFORMATION

Alternate Name: _____ Reason for alternate name: Alias
 Foreign Born/Americanized Name
 Other, specify: _____
 Unknown

Inmate Instructions: The following applies to NYS Department of Corrections (DOCS) Inmates only (do not enter information for federal, out of state or county jail inmates). Please enter the DOCS Department Identification Number (DIN) that was assigned to the patient at the time of the FIRST positive hepatitis test result. Inmates may have multiple DINs over their lifetime; however, please do not change the DIN originally reported. “County of Commitment” is the county in which the inmate was convicted. NYSDOCS inmate information can be located online at: <http://nysdocslookup.docs.state.ny.us/>.

DIN: _____ (XX-X-XXXX) County of Commitment: _____

CLINICAL INFORMATION

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Did the patient have a discrete onset of symptoms at time of diagnosis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, symptom onset date: ___/___/___</i> | | | |
| <i>If yes, symptoms:</i> | | | |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dark Urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Clay-colored bowel movements | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other, Specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Was patient jaundiced at time of diagnosis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, jaundice onset date: ___/___/___</i> | | | |

Reason for Testing (Select all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Symptoms of acute hepatitis <input type="checkbox"/> Screening of a patient with no symptoms, with reported risk factors <input type="checkbox"/> Screening of a patient with no symptoms, no reported risk factors (e.g., patient request) <input type="checkbox"/> Prenatal screening <input type="checkbox"/> Blood/organ/tissue donor screening <input type="checkbox"/> Evaluation of elevated liver enzymes <input type="checkbox"/> Dialysis screening <input type="checkbox"/> Routine physical <input type="checkbox"/> Life/health insurance screening <input type="checkbox"/> Pre-surgical screening <input type="checkbox"/> Occupational health screening | <input type="checkbox"/> Born to HBV-positive mother <input type="checkbox"/> Contact of a confirmed case <input type="checkbox"/> Drug treatment screening <input type="checkbox"/> Refugee/Immigration screening <input type="checkbox"/> International adoptee screening <input type="checkbox"/> Post-exposure screening <input type="checkbox"/> Patient received notification of possible exposure <input type="checkbox"/> Pre-vaccination screening <input type="checkbox"/> Post-vaccination screening <input type="checkbox"/> Other, specify: _____ |
|--|---|

| | Yes | No | Unk |
|--|--------------------------|--------------------------|--------------------------|
| If patient was hospitalized at the time of diagnosis, was the patient hospitalized specifically for hepatitis B? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Was patient pregnant at the time of diagnosis? If yes, due date: ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did patient die due to complications from hepatitis B (i.e., primary cause of death)? If yes, date of death: ___/___/___ ICD code (State DOH only): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Was the patient previously diagnosed with another hepatitis virus? Yes No Unk

If yes, type:

| | Yes | No | Unk | |
|---------------------|--------------------------|--------------------------|--------------------------|----------------|
| Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CDESS #: _____ |
| Acute Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CDESS #: _____ |
| Chronic Hepatitis C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CDESS #: _____ |
| Hepatitis E | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CDESS #: _____ |

Has the patient ever donated blood?
 If yes, date of last donation: (MM/YYYY) ___/___/___

If this case has a diagnosis of hepatitis B and has not had laboratory testing, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis B case?

EPIDEMIOLOGIC RISK FACTORS

Risk Factor Instructions: Please ask all risk factor questions based on the patients incubation period, 6 weeks to 6 months prior to the onset of symptoms. Risk factors listed on this form are by no means exhaustive. Please gather as much detail about risk factors as possible. Details can be recorded in the comments section if there is not already a space on the form for the information. This section is important in the identification of outbreaks and missed opportunities for prevention.

Patient country of birth*: _____ Exposure window: ___/___/___ to ___/___/___

Note: Exposure window/incubation period calculators can be found online at <http://www.nyhealth.gov/diseases/communicable/hepatitis/surveillance.htm>. The exposure window or incubation period for hepatitis B virus infection is 6 weeks to 6 months prior to the onset of symptoms.

CLOSE CONTACTS:

During the 6 weeks-6 months prior to onset of symptoms:

Was the patient a contact of a person with a confirmed or suspected hepatitis B virus infection? Yes No Unk

If yes, type of contact:

| | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| Household member (non-sexual) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Non-household relative/friend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| IV drug use partner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Non-IV drug use partner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Caretaker of HBV positive patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other, specify _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HEALTHCARE EXPOSURES:

Instructions: If the patient reports healthcare exposure(s) during the incubation period, please obtain as much detail regarding the procedure(s) as possible.

If healthcare related transmission of hepatitis is suspected, please refer to the Guidelines for Investigating Cases of Possible Healthcare Transmission of Bloodborne Pathogens found on the HCS at https://commerce.health.state.ny.us/hin/hinapps/hepatitis/FINAL_GUIDELINES_113009.pdf.

Physician license numbers can be looked up online at http://www.health.state.ny.us/professionals/doctors/conduct/license_lookup.htm.

Other providers, such as dentists and acupuncturists, can be looked up on line at <http://www.op.nysed.gov/opsearches.htm>.

Facility ID (formerly PFI) numbers can be looked up on the HPN, using the Health Facilities Information System (HFIS) application. <https://commerce.health.state.ny.us/doh2/applinks/hfis/index.jsp>.

During the 6 weeks to 6 months prior to onset of symptoms did the patient:

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Undergo hemodialysis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| From Date: ___/___/___ To Date: (MM/DD/YYYY) ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Physician Name: _____ | | | |
| Physician License #: _____ | | | |
| | | | |
| Receive blood or blood products (transfusion)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date: ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Physician Name: _____ | | | |
| Physician License #: _____ | | | |
| | | | |
| Receive any IV infusions and/or injections? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of infusion/injection: _____ | | | |
| Date: ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Physician Name: _____ | | | |
| Physician License #: _____ | | | |

During the 6 weeks to 6 months prior to onset of symptoms did the patient:

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Have surgery in an outpatient setting (e.g., colonoscopy, cataract surgery, biopsy, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify Procedure: _____ | | | |
| Date: ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Physician Name: _____ | | | |
| Physician License #: _____ | | | |
| | | | |
| Have surgery in an inpatient setting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify Procedure: _____ | | | |
| Date: ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Physician Name: _____ | | | |
| Physician License #: _____ | | | |
| | | | |
| Require hospitalization (prior to onset of acute hepatitis symptoms)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| From Date: ___/___/___ To Date: (MM/DD/YYYY) ___/___/___ | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| | | | |
| Have dental work or oral surgery (excluding routine dental cleaning)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify Procedure: _____ | | | |
| Date: ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Physician Name: _____ | | | |
| Physician License #: _____ | | | |
| | | | |
| Reside in a long-term care facility? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| From Date: ___/___/___ To Date: (MM/DD/YYYY) ___/___/___ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Receive fingersticks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

During the 6 weeks to 6 months prior to onset of symptoms did the patient:

| | Yes | No | Unk |
|--|--------------------------|--------------------------|--------------------------|
| Receive home health care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify exposure(s): _____ | | | |
| From Date: ____/____/____ To Date: (MM/DD/YYYY) ____/____/____ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Provider Name: _____ | | | |
| Provider License #: _____ | | | |
| | | | |
| Receive any alternative healthcare (e.g., acupuncture)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify exposure(s): _____ | | | |
| From Date: ____/____/____ To Date: (MM/DD/YYYY) ____/____/____ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Provider Name: _____ | | | |
| Provider License #: _____ | | | |
| | | | |
| Receive any healthcare outside of the U.S. or Canada? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify procedures(s): _____ | | | |
| From Date: ____/____/____ To Date: (MM/DD/YYYY) ____/____/____ | | | |
| Location*: _____ | | | |
| | | | |
| Other healthcare exposure(s)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify Procedure(s): _____ | | | |
| Date: ____/____/____ | | | |
| Facility Type: (Article 28 or Non-Article 28) | | | |
| Facility Name: _____ | | | |
| ID (A28 Only): _____ | | | |
| Provider Name: _____ | | | |
| Provider License #: _____ | | | |

OCCUPATIONAL EXPOSURES:

During the 6 weeks to 6 months prior to onset of symptoms:

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) involving direct contact with human blood? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Frequency of direct blood contact:</i> | | | |
| Frequent (several times weekly) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Infrequent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Was the patient employed in a medical or dental field involving direct contact with human blood? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Frequency of direct blood contact:</i> | | | |
| Frequent (several times weekly) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Infrequent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Was the patient an employee in a dialysis center? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did the patient have an accidental stick or puncture with a needle, lancet or other sharp object contaminated with blood? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did the patient have any mucosal exposures (e.g., blood splash to the eyes)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TRAVEL HISTORY:

Note: If the patient visited or lived in more than one country during the 6 weeks to 6 months prior to onset of symptoms, additional locations may be noted in the comments section.

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Did the patient travel or live outside of the U.S. or Canada: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide details: | | | |

Country*: _____ Departure Date: ____/____/____ Return Date: ____/____/____

Reason for travel:

- Tourism
- Business
- Visiting friends or relatives
- Recent immigrant
- International adoption
- Military
- Other, specify: _____

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Did the patient stay at a resort? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify resort name: _____ | | | |
| Did the patient travel on a cruise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify cruise ship name: _____ | | | |

LIFESTYLE RISK FACTORS:

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Is the patient diabetic? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, does the patient use a blood glucose monitor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, does the patient inject insulin at home? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to either of these, does anyone else use your equipment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

During the 6 weeks to 6 months prior to onset of symptoms, did the patient:

Have any exposure to someone else's blood (e.g., physical fight, assist with wound care)? Yes No Unk

Specify exposure: _____

Have sexual contact with a person born outside of the US or Canada? Yes No Unk

If yes, where was the person born (country*): _____

Note: Please ask the following 2 questions regardless of patient's gender:

During the 6 weeks to 6 months before symptom onset, how many:

Male sex partners did the patient have: 0 1 2-5 >5 Unknown

Female sex partners did the patient have: 0 1 2-5 >5 Unknown

What is the patient's sexual preference?

Heterosexual Homosexual Bisexual Refused

| | Yes | No | Unk |
|--|--------------------------|--------------------------|--------------------------|
| Did the patient inject drugs not prescribed by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, type(s) of drug(s):

Street Drugs Yes No Unk

Steroids Yes No Unk

Other, specify: _____ Yes No Unk

If yes, did the patient share drugs with others? Yes No Unk

If yes, did the patient share equipment/paraphernalia with others? Yes No Unk

If yes, did the patient share needles with others? Yes No Unk

Did the patient ever use street drugs but not inject? Yes No Unk

If yes, method(s) of drug use:

Smoked Yes No Unk

Snorted Yes No Unk

Ingested orally Yes No Unk

Inhaled Yes No Unk

Anal insertion Yes No Unk

Other, specify: _____ Yes No Unk

If yes, did the patient share drugs with others? Yes No Unk

If yes, did the patient share equipment/paraphernalia with others? Yes No Unk

Was the patient ever incarcerated for more than 24 hours? Yes No Unk

If yes, type of facility:

- Prison
- County jail
- Juvenile facility
- Other, specify: _____

Start date: ____/____/____

End date: ____/____/____

Did the patient ever receive a tattoo? Yes No Unk

If yes, where was the tattoo performed:

- Commercial parlor/shop
- Correctional facility
- Private residence
- Tattoo party
- Other, specify: _____

Name of artist and/or shop: _____ Location: _____

Date: ____/____/____

Did the patient ever have any part of their body pierced (other than ear)? Yes No Unk

If yes, where was the piercing performed :

- Commercial parlor/shop
- Correctional facility
- Private residence
- Piercing party
- Other, specify: _____

Name of artist and/or shop: _____ Location: _____

Date: ____/____/____

LABORATORY DATA:

Note: The laboratory test results listed in bold type below are those which are required in order to determine case status. *The most efficient means of populating the CDESS forms with laboratory data is to transfer the information from ECLRS electronically versus manually adding a new case report and results. Additional instructions for completing the laboratory testing grid on CDESS can be found in the 2011 Viral Hepatitis Surveillance Guidelines.*

| Test Type | Test Date | Positive | Negative | Other Numeric Result |
|------------------|-------------|--------------------------|--------------------------|--|
| Total anti-HAV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| IgM anti-HAV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HBsAg | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| Anti-HBs | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| Total anti-HBc | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| IgM anti-HBc | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HBeAg | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HBeAb | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HBV NAT | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HBV Genotype | ___/___/___ | | | |
| Anti-HCV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Positive signal-to-cutoff ratio <input type="checkbox"/> Negative signal-to-cutoff ratio <input type="checkbox"/> Signal-to-cutoff ratio not reported |
| Anti-HCV by RIBA | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HCV NAT | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HCV Genotype | ___/___/___ | | | |
| Total anti-HDV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| IgM anti-HDV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HDAg | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| HDV NAT | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| Total anti-HEV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| IgM anti-HEV | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| ALT { SGPT } | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |
| AST { SGOT } | ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | |

Did the patient have any PRIOR NEGATIVE hepatitis B test results? Yes No Unk
 If yes, test type:
 HBsAg Date of Test: ___/___/___

VACCINE HISTORY:

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Did patient ever receive hepatitis A vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many doses: <input type="checkbox"/> 1 <input type="checkbox"/> 2+ | | | |
| If yes, date of last dose: ____/____/____ | | | |
| | | | |
| Did the patient ever receive hepatitis B immunoglobulin? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of last dose? ____/____/____ | | | |
| | | | |
| Did the patient ever receive hepatitis B vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many doses: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> >=3 | | | |
| If yes, date of last dose? ____/____/____ | | | |
| If yes, was patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose of vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, did the anti-HBs indicate immunity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

INSURANCE/TREATMENT INFORMATION

| | Yes | No | Unk |
|---|--------------------------|--------------------------|--------------------------|
| Does the patient have health insurance? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, type: | | | |
| Private Insurance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicaid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicare | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other, specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| Is the patient currently being monitored by a health care provider for hepatitis B infection? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | |
| Is the patient currently on treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CONTROL MEASURES

Please note: The CDC recommends that patients diagnosed with hepatitis B virus be vaccinated against hepatitis A in order to prevent further liver damage.

If patient was not vaccinated for hepatitis A, what was the reason?

Immune due to natural infection

Refused

Not offered

Other, specify: _____

Please Note: The CDC recommends providing hepatitis B immunoglobulin and/or vaccine to close contacts of acute hepatitis B patients.

Total number of at-risk close contacts eligible for HBIG: _____

Number of at-risk/eligible close contacts who received HBIG: _____

Total number of at-risk close contacts eligible for hepatitis B vaccine: _____

Number of at-risk/eligible close contacts who received hepatitis B vaccine: _____

COUNSELING INFORMATION

| | | Yes | No | Unk |
|-----------------------|-------------------|--------------------------|--------------------------|--------------------------|
| Provided by Physician | Date: ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Provided by LHD | Date: ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Provided by NYSDOH | Date: ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

LOCAL HEALTH DEPARTMENT FOLLOW-UP

Investigation Start Date: ___/___/___

Method of initial healthcare provider follow-up:

- Dear Doctor Letter Sent Date: ___/___/___
- Telephone call to provider
- Medical Record Review
- Electronic Medical Record Review
- Other
- None

Received Date: ___/___/___

| | | Yes | No | Unk |
|--------------------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| Was healthcare provider interviewed? | Interview Date: ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Did healthcare provider confirm acute HBV infection?

- Yes
- No If no, alternate diagnosis: _____
- No Response
- Not Attempted

| | | Yes | No | Unk |
|------------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| Was the patient interviewed? | Interview date: ___/___/___ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Method of patient-follow-up:

- Telephone call to patient
- Chart Review
- Other, specify: _____
- None

Comments:

Investigated by: _____ Date Investigation completed: ___/___/___

**A list of countries can be found in the 2011 Viral Hepatitis Surveillance Guidelines.*