

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Serial Number: \_\_\_\_\_

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

**General Instructions:** All suspected chronic hepatitis B cases should be followed-up, beginning with clinical information obtained from the provider; however, providers may not have all of the information necessary to complete this form. If follow-up with patient is feasible, 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. The information gathered assists in determining the epidemiologic profile of the disease in New York State, which in turn aids in prevention planning. 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**

**Note:** Please answer the following clinical questions for the period when the patient was first diagnosed with **chronic hepatitis B virus**, or the first positive report in the absence of acute infection. Please do not enter clinical symptoms from prior acute hepatitis B infections.

	Yes	No	Unk
Did the patient have a discrete onset of symptoms at time of first positive test result?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes, symptom onset date:</b> ___/___/___			
<b>If yes, symptoms:</b>			
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"/>
<b>If yes, jaundice onset date:</b> ___/___/___			

**Reason for Testing (Select all that apply):**

**Note:** Reason for testing corresponds to the first positive **chronic** hepatitis B test reported to the health department. Please do not enter the reason for testing that corresponds to a prior acute hepatitis B diagnosis.

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

**Ordering Facility Setting Type (for first reported positive test result):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Community Based Organization<br><input type="checkbox"/> Community Health Center<br><input type="checkbox"/> County Jail<br><input type="checkbox"/> Dialysis Center<br><input type="checkbox"/> Drug Treatment-Inpatient<br><input type="checkbox"/> Drug Treatment-Outpatient | <input type="checkbox"/> Emergency Department<br><input type="checkbox"/> HIV Counseling & Testing Site<br><input type="checkbox"/> Hospital-Inpatient<br><input type="checkbox"/> NYS Department of Corrections<br><input type="checkbox"/> Occupational Health<br><input type="checkbox"/> Primary Care Facility | <input type="checkbox"/> Public Health Clinic<br><input type="checkbox"/> Surgical Center<br><input type="checkbox"/> Syringe Exchange Program<br><input type="checkbox"/> Veteran's Affairs (VA) Facility<br><input type="checkbox"/> Other, Specify: _____<br><input type="checkbox"/> Unknown |
|--|--|--|

Ordering Provider Type (for first reported positive test result):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Gastroenterology/Hepatology | <input type="checkbox"/> HIV Provider                   | <input type="checkbox"/> Other, Specify: _____ |
| <input type="checkbox"/> Infectious Disease          | <input type="checkbox"/> Pediatrician/Adolescent Health | <input type="checkbox"/> Unknown               |
| <input type="checkbox"/> Internal Medicine           | <input type="checkbox"/> OB/GYN                         |  |
| <input type="checkbox"/> Family Practice             | <input type="checkbox"/> Mental Health                  |  |

	<b>Yes</b>	<b>No</b>	<b>Unk</b>
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"/>
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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"/>
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Was the patient previously diagnosed with another hepatitis virus? If yes, type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<b>Yes</b>	<b>No</b>	<b>Unk</b>	
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CDESS #: _____
Acute Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CDESS #: _____
Perinatal Hepatitis B	<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 #: _____

	<b>Yes</b>	<b>No</b>	<b>Unk</b>
Has the patient ever donated blood? If yes, date of last donation: (MM/YYYY) ___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EPIDEMIOLOGIC RISK FACTORS**

**Risk Factor Instructions:** Please ask all risk factor questions based on the patient's lifetime history *and* record the date of the *most recent* exposure to the specific risk factor. Lifetime risk factor information provides useful data to inform prevention planning and programs. In addition, it is important that on-going or recent risk behavior data is collected to determine if the patient may be engaging in behaviors that may put others at risk for infection.

**Endemic Countries:**

Patient country of birth:\* \_\_\_\_\_

**Contact Exposures:**

	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>Date of most recent exposure</b>
Was the patient a contact of a person with a confirmed or suspected hepatitis B virus infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
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"/>	
Born to HBV positive mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Healthcare Exposures:**

	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>Date of most recent exposure</b>
Was the patient ever on long-term hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Did the patient ever reside in long-term care facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
If yes, did the patient receive fingersticks (i.e., glucose monitoring device)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Did the patient ever receive healthcare outside of the US or Canada?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
If yes, country*: _____				

**Occupational Exposures:**

	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>Date of most recent exposure</b>
Was the patient ever employed as a public safety worker with direct blood contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Was the patient ever employed in a medical or dental field with direct blood contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Was the patient ever employed 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 ever have an occupational mucosal exposure (e.g., blood splash to the eyes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__

<u>Lifestyle Exposures:</u>	Yes	No	Unk	Date of most recent exposure
Did the patient ever have an accidental stick or puncture wound from an object potentially contaminated with blood (NON-OCCUPATIONAL)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Is the patient diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, did the patient ever share a glucose monitoring device?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Did the patient ever have any non-occupational exposure to someone else's blood (i.e., fist fight)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Did the patient ever live outside the US or Canada	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, country*: _____				
If yes, From date: ___/___/___ To date: ___/___/___				

***Please answer the following 2 questions regardless of patient's gender:***

How many lifetime male sex partners did the patient have	<b>CIRCLE: 0 /1/ 2-5/ &gt;5</b>
How many lifetime female sex partners did the patient have	<b>CIRCLE: 0 /1/ 2-5/ &gt;5</b>

What is the patient's sexual preference?

Heterosexual     Homosexual     Bisexual     Refused

Did the patient ever have sexual contact with a person born outside the US or Canada	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, where (country*) was the person born _____				

Did the patient ever inject drugs not prescribed by a doctor (even if only once)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, type(s) of drug(s):				
Street Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, did the patient share drugs with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, did the patient share equipment/paraphernalia with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, did the patient share needles with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___

Did the patient ever use street drugs but not inject?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, method(s) of drug use:				
Smoked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Snorted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Ingested orally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Anal insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, did the patient share drugs with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___
If yes, did the patient share equipment/paraphernalia with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_/_/___

	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>Date of most recent exposure</b>
Was the patient ever incarcerated for more than 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
If yes, type of facility				
<input type="checkbox"/> Prison				
<input type="checkbox"/> County jail				
<input type="checkbox"/> Juvenile facility				
<input type="checkbox"/> Other, specify: _____				
	Start date: __/__/__		End date: __/__/__	

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Did the patient ever receive a tattoo?				
If yes, where was the tattoo performed:				
<input type="checkbox"/> Commercial parlor/shop				
<input type="checkbox"/> Correctional facility				
<input type="checkbox"/> Private residence				
<input type="checkbox"/> Tattoo party				
<input type="checkbox"/> Other, specify: _____				
Name of artist and/or shop: _____	Location: _____			

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	__/__/__
Did the patient ever have any part of their body pierced (other than ear)?				
If yes, where was the piercing performed :				
<input type="checkbox"/> Commercial parlor/shop				
<input type="checkbox"/> Correctional facility				
<input type="checkbox"/> Private residence				
<input type="checkbox"/> Piercing party				
<input type="checkbox"/> Other, specify: _____				
Name of artist and/or shop: _____	Location: _____			

**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 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"/>
Did the patient ever receive treatment for hepatitis B infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date of last treatment: ___/___/___			
Is the patient currently on treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Control Measures:**

*(Prevention of secondary infections and transmission to others)*

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: \_\_\_\_\_

**Please note:** The CDC recommends that patients diagnosed with hepatitis B virus be vaccinated against hepatitis A in order to prevent further liver damage. For more information, please refer to MMWR, September 19, 2008 / Vol. 57 / No. RR-8 *Recommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection.*

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

Immune due to natural infection

Refused

Not offered

Other, Specify: \_\_\_\_\_

**Counseling Information**

**Yes      No      Unk**

Provided by Physician      Date: \_\_\_/\_\_\_/\_\_\_  
Provided by LHD      Date: \_\_\_/\_\_\_/\_\_\_  
Provided by NYSDOH      Date: \_\_\_/\_\_\_/\_\_\_

             
              
           

**Local Health Department Follow-up**

Investigation Start Date: \_\_\_/\_\_\_/\_\_\_

Method of initial healthcare provider follow-up:

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

**Yes      No      Unk**

Was healthcare provider interviewed?      Interview Date: \_\_\_/\_\_\_/\_\_\_

          

Did healthcare provider confirm chronic HBV infection?

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

**Yes      No      Unk**

Was the patient interviewed?      Interview date: \_\_\_/\_\_\_/\_\_\_

          

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.*