TEXAS Health and Human Services | Texas Department of State Health Services

Infectious Disease Control Unit, Texas Department of State Health Services
P.O. Box 149347, MC 1960
Austin, Texas 78714
Phone: (512) 776-7676 Fax: (512) 776-7616
VPDTexas@dshs.texas.gov

Hepatitis B, Acute Case Track Record

FINAL STATUS:
- ☐ CONFIRMED, ACUTE
- ☐ CONFIRMED, CHRONIC
- ☐ RULED OUT /NOT A CASE

NBS PATIENT ID#: _____

NBS INVESTIGATION ID#: _____

Patient's Name: _____ (last) (first)
Address: _____
City: _____ County: _____ Zip: _____
Region: _____ Phone: ( ) _____
Parent/Guardian: _____
Physician: _____ Phone: ( ) _____
Address: _____
_____
☐ Check box if history of homelessness in last 6 months

Reported by: _____
Agency: _____
Phone: ( )_____
Date reported: ____/____/____
Investigated by: _____
Agency: _____
Phone: ( ) _____
Email:_____
Investigation start date: ____/____/____
Date investigation completed: ____/____/____

DEMOGRAPHICS: *DATE OF BIRTH:* _____/_____/_____ *AGE:* _____ *PLACE OF BIRTH:* ☐USA ☐Other:_____ ☐Unknown

SEX: ☐ Male ☐ Female ☐ Unknown

RACE: ☐White ☐Black ☐Asian ☐Native Hawaiian or Other Pac. Islander ☐Am. Indian or Alaska Native ☐Unknown ☐Other: _____

HISPANIC: ☐ Yes ☐ No ☐ Unknown

If female, is patient currently pregnant? ☐Yes ☐No ☐Unknown

If yes, estimated date and location of delivery: ____/____/____

Obstetrician's name, address, and phone #: _____

Was the patient hospitalized for this illness? ☐Yes /☐No

Hospitalized at: _____

Admitted: ____/____/____ Discharged: ____/____/____

Duration of Stay_____days

Reason for testing:
- ☐ Evaluation of elevated liver enzymes
- ☐ Follow-up testing (prior viral hepatitis maker)
- ☐ Screening of asymptomatic patient w/ risk factors
- ☐ Screening of asymptomatic patient w/o risk factors
- ☐ Symptoms of acute Hepatitis
- ☐ Unknown
- ☐ Other:

CLINICAL DATA

Diagnosis Date: _ __/__ _/_ __

	Yes	No	Unk
Is patient symptomatic?.....	☐	☐	☐
If yes, onset date: ____/____/____ End date: ____/____/____			
(Fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain)			
Was the patient			
*Jaundiced?.....	☐	☐	☐
*Hospitalized for Hepatitis?.....	☐	☐	☐
Did the patient die from hepatitis?.....	☐	☐	☐
Date of death: ____/____/____			

LABORATORY TESTING (*Check all that apply*)

Date of lab test____/____/_____	POS	NEG	UNK
Hepatitis B surface antigen [HBsAg]……..	☐	☐	☐
Total antibody to hepatitis B core antigen [total anti-HBc]...	☐	☐	☐
IgM antibody to hepatitis B core antigen [IgM anti-HBc]…..	☐	☐	☐

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

ALT [SGPT] Result_____ Upper limit normal_____

AST [SGPT] Result_____ Upper limit normal_____

Date of ALT result____/____/____

Date of AST result____/____/____

VACCINATION HISTORY

	Yes	No	Unk
Did the patient ever receive hepatitis B vaccine?	☐	☐	☐
If yes, how many shots?.....	1 ☐	2 ☐	3+ ☐
In what year was the last shot received?.....	_____		

	Yes	No	Unk
Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?.....	☐	☐	☐
If yes, was the serum anti-HBs >10mIU/ml?..... (answer 'yes ' if the laboratory result was reported as 'positive' or 'reactive')	☐	☐	☐

***Please send all perinatal surveillance forms (*Mother Case Management Report and/or Infant Case Management Report*) to the Perinatal Hepatitis B Prevention Program at:** Phone: (512) 533-3158 Fax: (512) 533-3167

Patient History – Hepatitis B, Acute Pt. Name:_____ NBS Pt. ID:_____

CONTACT WITH A CASE

During the **6 weeks-6 months** prior to onset of symptoms was the patient a contact of a confirmed or suspected acute or chronic hepatitis B case? ……..... Yes ☐ No ☐ Unk ☐

If yes, type of contact:

- Sexual…… ☐ ☐ ☐
- Household (non-sexual)…….. ☐ ☐ ☐
- Other…….. ☐ ☐ ☐

SEXUAL AND DRUG EXPOSURES

Please ask both of the following questions regardless of the patient's gender.

In the **6 months** before symptom onset how many: 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unk ☐

- Male sex partners did the patient have?..... ☐ ☐ ☐ ☐ ☐
- Female sex partners did the patient have?. ☐ ☐ ☐ ☐ ☐

Was the patient ***EVER*** treated for a sexually-transmitted disease?..... Yes ☐ No ☐ Unk ☐

If yes, in what year was the most recent treatment?..... _____

BLOOD EXPOSURES PRIOR TO ONSET

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

Did the patient:

- Undergo hemodialysis?..... Yes ☐ No ☐ Unk ☐
- Have an accidental stick or puncture with a needle or other object contaminated with blood?..... ☐ ☐ ☐
- Receive blood or blood products [transfusion]…. ☐ ☐ ☐
  If yes, when?_____/_____/_____
- Receive any IV infusions and/or injections in the outpatient setting?..... ☐ ☐ ☐
- Have other exposure to someone else's blood?.. ☐ ☐ ☐
  specify: _____

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

Was the patient employed in a medical or dental field Involving direct contact with human blood?..... ☐ ☐ ☐

If yes, frequency of direct blood contact:
Frequent (several times weekly) ☐ Infrequent ☐

Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having contact with human blood?..... ☐ ☐ ☐

If yes, frequency of direct blood contact:
Frequent (several times weekly) ☐ Infrequent ☐

TATTOOING/DRUGS/PIERCING

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

Did the patient receive a tattoo?..... Yes ☐ No ☐ Unk ☐

Where was the tattooing performed? ***(select all that apply)***

☐ Commercial parlor/shop ☐ Correctional facility ☐ other_____

- Inject drugs not prescribed by a doctor?.....
- Use street drugs but not inject?.....

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

- Did the patient have any part of their body pierced (other than ear)?

Where was the piercing performed? ***(select all that apply)***

☐ Commercial parlor/shop ☐ Correctional facility ☐ other_____

OTHER HEALTHCARE EXPOSURE

- Did the patient have dental work or oral surgery?.... Yes ☐ No ☐ Unk ☐
- Did the patient have surgery?..... ☐ ☐ ☐
- Was the patient –*(check all that apply)*
  -hospitalized?..... ☐ ☐ ☐
  -a resident of a long term care facility?..... ☐ ☐ ☐
  -incarcerated for longer than 24 hours?..... ☐ ☐ ☐

INCARCERATION PRIOR TO ONSET

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

- Was the patient in: Yes / No
  Prison…… ☐ ☐
  Jail…….. ☐ ☐
  Juvenile facility…… ☐ ☐

INCARCERATION MORE THAN 6 MONTHS

During his/her lifetime, was the patient ***EVER***

- Incarcerated for longer than 6 months?..... Yes ☐ No ☐ Unk ☐
  If yes,
  -what year was the most recent incarceration?..... _____
  -for how long?…… ___ ___ months.

Non-sexual Household and Sexual Contacts Requiring Prophylaxis:

Name	Relation to Case	Age	HBIG	HB Vaccine
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

Control Measures ***(check all that apply):***

☐ Notified blood center(s)
☐ Notified dialysis center, surgeon(s), acupuncturist, and/or tattoo parlor
☐ Disinfected all equipment contaminated with blood or infectious body fluids
☐ Vaccinated susceptible contacts
☐ Notified delivery hospital and obstetrician if a woman is pregnant
☐ Vaccinated infant born to HBsAg-positive women

Comments: