## Appendix 2: Sample hepatitis B case report form for public health units

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| *Attach laboratory record and contact lists if applicable. Ensure required information is recorded on the State/Territory data record system and the National Notifiable Diseases Surveillance System* | | | | | | |
| Notification Information  Hepatitis B Case Report Form | | | | | | |
| **Health centre/practice/laboratory** | | |  | **Health centre/practice phone no.** |  | **Health centre/lab state** |
|  |  |  |  |  |  |  |
| **Treating clinician** |  |  |  | **Clinician phone number** |  | **Clinician state** |
|  | | |  |  |  |  |
| **Notifier** |  | **Notification date** |  | **Notification receive date** |  | **Notification ID** |
|  |  | / / |  | / / |  |  |
| **Test requested by** | | |  | **Disease code** |  | **Organism code** |
|  | | |  |  |  |  |
| **Permission to contact the patient directly** | | |  | **Organism name** |  | **Detection code** |
| Yes  No | | |  |  |  |  |
|  | | |  |  |  |  |
| *Summary information for notification* | | | | | | |
| **Case found by** | | |  | **Case category** *(refer to laboratory confirmation of case category)* |  | **Confirmation status** |
| Clinical presentation | | |  | Newly acquired hepatitis B |  | Confirmed |
| Contact tracing/epidemiological investigation | | |  | Hepatitis B unspecified |  | Probable |
| Screening (excluding antenatal) | | |  |  |  | **HBV detection** |
| Clinical and epidemiology | | |  |  |  | Yes |
| Antenatal screening | | |  | Date of last HBV negative test |  | No |
| Unknown | | |  | / / |  | Unknown |
| True onset date (the earliest date the case exhibited symptoms) | | |  | Place of acquisition (SACC code) |  | Public health response date |
| / / or  N/A for asymptomatic | | |  |  |  | / / |
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| **Family Name** |  | | | | |  | **Given Name** | | | | | |  | |
|  | | | | | |  |  | | | | | | | |
| **Date of Birth** |  | | **Age at onset** (or notification if asymptomatic/unknown onset) | | | | |  | | | **Patient UR No.** | | | |
| / / |  |  | | | | |  | | |  | | | |  |
|  | | | | | | |  | | | | | | | |
| **Sex** |  | | | | | | **Country of Birth** | | | | | | | |
| Male | |  | | | | | Australia (1101) | | | | | | | |
| Female |  | | | | | | Overseas– Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SACC:\_\_\_\_\_\_ | | | | | | | |
| Other, specify: |  | | | | | | Unknown (0004 if overseas but no specific country) | | | | | | | |
| **Is the person of Aboriginal or Torres Strait Islander (TSI) origin?**  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, Both Aboriginal and Torres Strait Islander  No  Unknown | | | | | | | **Is this person a healthcare worker (or training as a healthcare worker)?**  Yes, currently  Yes, previously date ceased: / /  No  Unknown | | | | | | | |
| **Address** | |  | | |  | |  | | **State** | | |  | | **Mobile phone number** |
|  | | | | | | |  | |  | | |  | |  |
| **Suburb/community** | |  | |  |  | |  | | **Postcode** | | |  | | **Other phone number** |
|  | | | | | | |  | |  | | |  | |  |

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| Clinical investigations and outcomes | | | | | | | | | |
| **Investigations –** *Please attach pathology results to this form* | | | | | | | | | |
| Serology specimen date \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | |
| Hepatitis B Surface Antigen  (HBsAg) | Detected | | Not Detected | | | Not Tested | | Unknown | |
| Hepatitis B core IgM  (anti-HBc IgM or HBc IgM) | Detected | | Not Detected | | | Not Tested | | | Unknown |
| HBsAb | Detected | | Not Detected | | | Not Tested | | | Unknown |
| HBcAb | Detected | | Not Detected | | | Not Tested | | | Unknown |
| HBeAg | Detected | | Not Detected | | | Not Tested | | | Unknown |
| HBeAb | Detected | | Not Detected | | | Not Tested | | | Unknown |
| PCR Specimen date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | | | |
| Hepatitis B PCR or DNA | Detected | | | Not Detected | | Not Tested | | | Unknown |
| **Liver function test** conducted? | Conducted | | | Not conducted | | **Test date**  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | |
| Liver function test result | Normal | | | Abnormal | |
| Has this person had a **negative** hepatitis B Surface Antigen test **within the last 24 months**? | | | | | Has this person ever been hospitalised due to Hepatitis B? | | Is this person alive?  Alive  No, died due to Hepatitis B  Date of death: / /  No, died due to other causes  Unknown | | |
| Yes, date of last negative test:  No  Unknown | | / / | | | Yes  Admission date: / /  Discharge date / /    Hospital name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unknown | |

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| **Laboratory confirmation of case category –** Is the case being categorised as: | | | | |
| Newly acquired hepatitis B because:  Hepatitis B surface antigen (HBsAg) positive; with a negative HBV test in the last 6 months/2 years  Detection of HBsAg and lgM to hepatitis B core antigen in the absence of prior evidence of hepatitis B virus infection  Hepatitis B PCR positive and lgM to hepatitis B core antigen in the absence of prior evidence of hepatitis B infection | | **OR** | Unspecified hepatitis B because:  Hepatitis B surface antigen (HBsAg) positive  Hepatitis B PCR positive  AND  The case does not meet any of the criteria for a newly acquired case | |
| Reason for Testing | | | | |
| Was this test performed to investigate symptomatic hepatitis? | | | | |
| **Has the patient had symptoms of acute hepatitis in the last two years?**  Yes  No  **Was this test performed to investigate symptomatic hepatitis?**  Yes  No | Reason for testing **asymptomatic** patient | | |  |
| Screening, specify type  Previous diagnosis/treatment for HBV  Patient request  Investigation of abnormal liver function tests  Contact tracing/epidemiological investigation  Occupational exposure (exposed)  Research or study  Other, specify(eg history of clinical illness, others with similar illness): | | | (Tick **one** option only)  Prison screen  Drug/Alcohol screen  STI screen  Antenatal screen  Post natal screen in a child with a HBV positive mother  Refugee screen  Blood or organ donor scheme  Perioperative test  Unknown/not recorded |
| Onset date if symptomatic:  / / |

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| Vaccination | | | | | | | | | | |
| **Has this person ever been vaccinated against Hepatitis B?**  Yes, course complete Complete the table below Date of last vaccination\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_  Yes, course incomplete  Not vaccinated  Unknown | | | | | | | | | | |
| Vaccine dose | 1 | | 2 | 3 | | | 4 | | | 5 |
| Vaccination date |  | |  |  | | |  | | |  |
| Vaccine type (brand name) |  | |  |  | | |  | | |  |
| Vaccination validation\* |  | |  |  | | |  | | |  |
| \*Vaccine information validated (i.e. from information system or medical records)/self or parent recall/information not collected | | | | | | | | | | |
| Risk factors | | | | | | | | | | |
| Has this person had any of the following risk factors(tick **all** options that apply for each risk factor): | | | | | | | | | | |
|  | | Yes, within the last two years | | | Yes, but more than two years ago | Never | | | Unknown | |
| Injecting drug use | |  | | |  |  | | |  | |
| Imprisonment | |  | | |  |  | | |  | |
| Sexual partner of opposite sex with HBV | |  | | |  |  | | |  | |
| Sexual partner of same sex with HBV | |  | | |  |  | | |  | |
| Household contact with HBV | |  | | |  |  | | |  | |
| Perinatal transmission | |  | | |  |  | | |  | |
| Tattoos | |  | | |  |  | | |  | |
| Acupuncture | |  | | |  |  | | |  | |
| Ear or body piercing | |  | | |  |  | | |  | |
| Occupational needlestick/biohazard injury in non- healthcare worker | |  | | |  |  | | |  | |
| Non-occupational needlestick/biohazard injury (other than IDU) | |  | | |  |  | | |  | |
| Healthcare-associated Risk Exposures | | | | | | | | | | |
| Has this person had any of the following risk exposures (tick **all** options that apply for each risk exposure): | | | | | | | | | | |
|  | | Yes, within the last two years | | | Yes, over two years ago | No | | Unknown | | |
| Haemodialysis | |  | | |  |  | |  | | |
| Surgical procedure | |  | | |  |  | |  | | |
| Major dental surgery (involving an anaesthetic) | |  | | |  |  | |  | | |
| Healthcare worker with no documented exposure | |  | | |  |  | |  | | |
| Occupational needlestick/biohazard injury in a healthcare worker | |  | | |  |  | |  | | |
| Blood/blood products/tissues in Australia | |  | | |  |  | |  | | |
| Blood/blood products/tissues Overseas | |  | | |  |  | |  | | |
| Organ transplantation in Australia | |  | | |  |  | |  | | |
| Organ transplantation Overseas | |  | | |  |  | |  | | |
| **Other risk factors/ no risk factors:**  No risk factors identified in the past two years  Non-IDU remote risk (i.e. non IDU risk identified, but not in the last two years)  *Provide details below.*  **Further details if required:** | | | | | | | | | | |

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| Contact management | | | | | | | | |
| **Did the case have close contact or high risk exposures (e.g. needle sharing, unprotected sex) with susceptible individuals while the case was infectious?**  Yes please complete below  No  Unknown | | | | | | | | |
| **Name of contact** | | **Type of contact** (household/ sexual/other) | | **Age** | | **Testing** | **Vaccination** | **Post-exposure HB Ig** |
|  | |  | |  | |  |  |  |
|  | |  | |  | |  |  |  |
|  | |  | |  | |  |  |  |
| Further details of case management/public health response | | | | | | | | |
| **Details of person completing this form (stamp acceptable)** | | | | |
| Name: | | | | |
|  | | | | |
| Position: | | | | |
|  | | | | |
| Phone: | | | | |
|  | | | | |
|  | | | | |
| **Is the case part of a known disease outbreak?** | | | | |
| Yes – outbreak reference number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unknown | | | | |
| **Advice to cases who are healthcare workers**  If the case is identified as a health care worker, have they been provided with advice in line with the national guidelines (refer to Australian National Guidelines for the management of health care workers known to be infected with blood-borne viruses)? | | | | | | | | |
| Yes | No | | Not applicable | | | | | |

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| **Data entry and case closed** | | | | | | | | | |
| **Reviewed** | | | | | **Data entered** | | | | |
| Date |  | Initials | |  | Date |  | Initials | |  |
| **Case closed** | | | | | | | | | |
| Date |  | Name |  | | Signature |  | | | |
| Any other comments? | |  | | |  |  | |  |  |
|  | | | | | | | | | |