

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

Attach laboratory record and contact lists if applicable. Ensure required information is recorded on the State/Territory data record system and the National Notifiable Disease Surveillance System

Notification Information

Health centre/practice/laboratory		Health centre/practice phone number	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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Organism name	Detection code

Summary information for notification

Case found by <input type="checkbox"/> Clinical presentation <input type="checkbox"/> Contact tracing/epidemiological investigation <input type="checkbox"/> Screening (excluding antenatal) <input type="checkbox"/> Clinical and epidemiology <input type="checkbox"/> Antenatal screening <input type="checkbox"/> Unknown	Case category (refer to laboratory confirmation of case category) <input type="checkbox"/> Newly acquired hepatitis B <input type="checkbox"/> Hepatitis B unspecified Date of last HBV negative test / /	Confirmation status <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable HBV detection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
True onset date (the earliest date the case exhibited symptoms) / / or <input type="checkbox"/> N/A for asymptomatic	Place of acquisition (SACC cc)	Public health response date / /

Family Name		Given Name	
Date of Birth	Age at onset (or notification if asymptomatic/unknown onset)	Patient UR No.	
/ /			
Sex		Country of Birth	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, specify:		<input type="checkbox"/> Australia (1101) <input type="checkbox"/> Overseas– Country: _____ SACC: _____ <input type="checkbox"/> Unknown (0004 if overseas but no specific country)	
Is the person of Aboriginal or Torres Strait Islander (TSI) origin		Is this person a healthcare worker (or training as a healthcare worker)	
<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, Both Aboriginal and Torres Strait Islander <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes, currently <input type="checkbox"/> Yes, previously → date ceased: / / <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Address		State	Mobile phone number
Suburb/community		Postcode	Other phone number

Clinical investigations and outcomes

Investigations – Please attach pathology results to this form

Serology specimen date ___/___/___

Hepatitis B Surface Antigen (HBsAg)	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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Hepatitis B core IgM (anti-HBc IgM or HBc IgM)	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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HBsAb	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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HBcAb	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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HBeAg	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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HBeAb	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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PCR Specimen date ___/___/___

Hepatitis B PCR or DNA	<input type="checkbox"/> Detected	<input type="checkbox"/> Not Detected	<input type="checkbox"/> Not Tested	<input type="checkbox"/> Unknown
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Liver function test conducted	<input type="checkbox"/> Conducted	<input type="checkbox"/> Not conducted	Test date
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Liver function test result	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	___/___/___
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Has this person had a **negative** hepatitis B Surface test **within the last 24 months?**

Yes, date of last negative test: ___ / ___ / ___

No

Unknown

Has this person ever been hospitalised due to Hepat

Yes ↓

Admission date: ___ / ___ / ___

Discharge date ___ / ___ / ___

Hospital name _____

No

Unknown

Is this person alive?

Alive

No, died due to Hepatitis B

Date of death: ___ / ___ / ___

No, died due to other causes

Unknown

Laboratory confirmation of case category – Is the case being categorised as:

Newly acquired hepatitis B because:

OR

Unspecified hepatitis B because:

Hepatitis B surface antigen (HBsAg) positive; with a negative HBV test in the months/2 years

Hepatitis B surface antigen (HBsAg) positive

Detection of HBsAg and IgM to hep core antigen in the absence of prior evic hepatitis B virus infection

Hepatitis B PCR positive

AND

Hepatitis B PCR positive and IgM to hepatitis B core antigen in the absence c evidence of hepatitis B infection

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 hepatitis in the last two years?

Yes

No

Was this test performed to invest symptomatic hepatitis?

Yes

No

Onset date if symptomatic:

/ /

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 simila illness):

(Tick **one** option only)

Prison screen

Drug/Alcohol screen

STI screen

Antenatal screen

Post natal screen in a child with a HBV posi mother

Refugee screen

Blood or organ donor scheme

Perioperative test

Unknown/not recorded

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 ye	Yes, but more than tw ago	Never	Unknown
Injecting drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imprisonment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual partner of opposite sex with HBV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual partner of same sex with HBV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household contact with HBV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perinatal transmission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tattoos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear or body piercing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational needlestick/biohazard injury in n healthcare worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-occupational needlestick/biohazard injury than IDU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 ye	Yes, over two year:	No	Unknown
Haemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgical procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major dental surgery (involving an anaesthetic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare worker with no documented expo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational needlestick/biohazard injury in a healthcare worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood/blood products/tissues in Australia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood/blood products/tissues Overseas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplantation in Australia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplantation Overseas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

Contact management

Did the case have close contact or high risk exposures (e.g. needle sharing, unprotected sex) with susceptible individuals while the case infectious?

Yes → please complete below

No

Unknown

Name of contact	Type of contact (household, sexual/other)	Age	Testing	Vaccination	Post-exposure HB

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

Data entry and case closed

Reviewed				Data entered			
Date		Initials		Date		Initials	
Case closed							
Date		Name		Signature			
Any other comments?							