Case name: ..... DOB ...../...../..... Notification ID: .....
First name *Surname*

Hepatitis B (Acute) Case Report Form

Queensland Government

Public Health Unit Outbreak ID: .....

Completed by: ..... Date sent to NOCS: ...../...../.....

Telephone: ..... Fax: .....

NOTIFICATION:

Date PHU notified: ...../...../..... Date initial response: ...../...../.....

Notifier: ..... Organisation: .....

Telephone: ..... Fax: ..... Email: .....

Treating Dr: .....

Telephone: ..... Fax: ..... Email: .....

CASE DETAILS: **UR No:** .....

Name: .....
First name *Surname*

Date of birth: ...../...../..... Age: .....Years ..... Months Sex: ☐ Male ☐ Female .....

Name of parent/carer: .....

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Non-Indigenous ☐ Unknown

English preferred language: ☐ Yes ☐ No – *specify* ..... Ethnicity – *specify* .....

Permanent address: .....

..... Postcode: .....

Home tel: ..... Mob: ..... Email: .....

Occupation: ..... Work telephone: .....

Temporary address in Queensland *(if different from permanent address)* : .....

..... Postcode: .....

Telephone: ..... Mob: ..... Email: .....

General Practitioner: Dr .....

Address: ..... Postcode: .....

Telephone: ..... Fax: ..... Email: .....

CLINICAL DETAILS:

Date of onset: ...../...../..... Date of onset of jaundice ...../...../.....

Reason for test: ☐ Acute disease ☐ Chronic infection ☐ Screening ☐ Other .....

Hospitalised: ☐ Yes ☐ No ☐ Unknown Hospital: ..... Date: ...../...../..... to ...../...../.....

Complications: ☐ Yes– *specify* ☐ No ☐ Unknown

Outcome: ☐ Survived ☐ Died Date of death: ...../...../..... ☐ Died of condition ☐ Unknown

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LABORATORY: Laboratory: ..... First collection date: ...../...../.....

Has the case ever had previous Hep B testing? ☐ Yes: ...../...../..... results ..... ☐ No ☐ Unknown

Serology ...../...../..... ☐ HBsAg + ☐ Anti-HBc IgM + ☐ Anti-HBc IgM - ☐ HBeAg + ☐ HBeAb +

PCR ...../...../..... ☐ HBV DNA detected ☐ HBV DNA not detected

Case name: ..... DOB ...../...../..... Notification ID: .....
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HEPATITIS B VACCINATION DETAILS:

Dose	Date	Type - Specify
1	...../...../.....	.....
2	...../...../.....	.....
3	...../...../.....	.....
4	...../...../.....	.....

Hepatitis B Vaccination status: ☐ Complete ☐ Incomplete ☐ Not vaccinated ☐ Unknown

Source of vaccination history: ☐ ACIR/VIVAS/Health Record ☐ Self/parental recall ☐ Unknown

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EXPOSURE PERIOD:

Date: ...../...../..... to Date: ...../...../.....
(date of onset – 6 months) (date of onset)

Are any of the following risk factors identified? If yes, please supply details below:

Ever injected drugs	☐ Yes	☐ No	☐ Unknown	Ear or body piercing	☐ Yes	☐ No	☐ Unknown
Injecting drug use in the previous 2 years	☐ Yes	☐ No	☐ Unknown	Perinatal transmission	☐ Yes	☐ No	☐ Unknown
Exposure to blood/body fluids, tissue in Australia	☐ Yes	☐ No	☐ Unknown	Heterosexual contact with person with HBV	☐ Yes	☐ No	☐ Unknown
Exposure to blood/body fluids, tissue overseas	☐ Yes	☐ No	☐ Unknown	Homosexual contact with person with HBV?	☐ Yes	☐ No	☐ Unknown
Haemodialysis	☐ Yes	☐ No	☐ Unknown	Imprisonment	☐ Yes	☐ No	☐ Unknown
Occupational needlestick in healthcare worker	☐ Yes	☐ No	☐ Unknown	Healthcare worker with no documented exposure	☐ Yes	☐ No	☐ Unknown
Occupational needlestick in non-healthcare worker	☐ Yes	☐ No	☐ Unknown	Household contact with HBV	☐ Yes	☐ No	☐ Unknown
Non-occupational or unspecified needlestick	☐ Yes	☐ No	☐ Unknown	Organ transplantation in Australia	☐ Yes	☐ No	☐ Unknown
Surgical work	☐ Yes	☐ No	☐ Unknown	Organ transplantation overseas	☐ Yes	☐ No	☐ Unknown
Major dental procedure	☐ Yes	☐ No	☐ Unknown	Other risk within the previous 2 years	☐ Yes	☐ No	☐ Unknown
Tattoos	☐ Yes	☐ No	☐ Unknown	Other risk but <u>not</u> within the previous 2 years	☐ Yes	☐ No	☐ Unknown
Acupuncture	☐ Yes	☐ No	☐ Unknown	Risk identified	☐ Yes	☐ No	☐ Unknown

Other details: .....

.....

.....

During this time was there contact with confirmed/suspected case(s)? ☐ Yes ☐ No ☐ Unknown

Name / NID: ..... Telephone: ..... Contact type: .....

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PLACE ACQUIRED:

☐ Queensland ☐ Other Australian state/territory *specify* .....

☐ Unknown ☐ Other country *specify* .....

NOTIFICATION DECISION: ☐ Acute Hepatitis B ☐ Hepatitis B-Unspecified ☐ Unknown

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INFECTIOUS PERIOD: (PHU use only)

A person may be infectious with hepatitis for many weeks prior to the onset of symptoms and remains infective through the acute clinical course of the disease and during the chronic carrier state, which may persist for life.

CONTACT MANAGEMENT:

Type of contact	Number of contacts	Management
Household	Children: ..... Adults:	No. of HBV immune contact ..... Testing ..... HBIG ..... Post exposure HB vaccination .....
Sexual	Children: ..... Adults:	No. of HBV immune contact ..... Testing ..... HBIG ..... Post exposure HB vaccination .....
Other	Children: ..... Adults:	No. of HBV immune contact ..... Testing ..... HBIG ..... Post exposure HB vaccination .....

COMMENTS: