Name:

HEPATITIS B CASE INVESTIGATION - Page 1 of 7
Indiana State Department of Health
State Form 52587 (R/11-09)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN
1. Type all data into form
2. Provide as much information as possible
3. Print copy for faxing to ISDH
4. Fax copy to Epidemiology Resource Center, ISDH
5. Date format: MM/DD/YYYY

Section 1: Demographics

First:
Middle:
Last:

If child, parent name (below):

First:
Middle:
Last:

Maiden Name:
Mother's Maiden:
Street Address:
City:
State: --Select State--
Zip:
County: --Select County--
Phone Number: --Type--
Date of Birth: ☐ Unknown
OR
Age: Years
SSN:
Gender: --Select Gender--
Race(s):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other/Multiracial
☐ Unknown
☐ White
Ethnicity: --Select Ethnicity--
Physician's Name:
Phone Number:
Fax Number:
Street Address:
City:
State: --Select State--
Zip:

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3
"This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is voluntary and you will not be penalized for refusal."

Section 1: Demographics (continued)

Occupation: --Select--

Employer Name:

Phone Number:

Street Address:

City:

State: --Select State--

County: --Select County--

Zip:

Section 2: Clinical

Health Care Provider:

Facility Type: --Select--

Facility:

Street Address:

City:

State: --Select State--

Zip:

Phone Number:

Reason for testing (check all that apply):

- ☐ Symptoms of acute hepatitis
  - ☐ Abdominal Pain
  - ☐ Dark urine
  - ☐ Diarrhea
    Onset Date:
  - ☐ Fatigue
  - ☐ Fever
    0 Degrees (F)
  - ☐ Jaundice
  - ☐ Loss of appetite
  - ☐ Nausea
  - ☐ Pale stool
  - ☐ Unknown
  - ☐ Other
    Specify:
- ☐ Evaluation of elevated liver enzymes
- ☐ Screening of asymptomatic patient with reported risk factors
- ☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- ☐ Blood/Plasma/Organ donor screening
- ☐ Follow-up testing for previous Hepatitis B marker
- ☐ Prenatal screening
- ☐ Immigrant screening
- ☐ Other
  Specify:
- ☐ Unknown

Section 2: Clinical (continued)

Pregnancy status for all females 12-50 years old:

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Due Date:

Date of onset:

Date of diagnosis:

Duration of symptoms: Days

Date of first positive specimen collected:

Diagnostic Tests (check all that apply):

Hepatitis B surface antigen (HBsAg):	☐ Positive	☐ Negative	☐ Not Done/Unknown
Total antibody to hepatitis B core antigen (Total anti-HBc):	☐ Positive	☐ Negative	☐ Not Done/Unknown
IgM antibody to hepatitis B core antigen (IgM anti-HBc):	☐ Positive	☐ Negative	☐ Not Done/Unknown
Antibody to hepatitis D virus (anti-HDV):	☐ Positive	☐ Negative	☐ Not Done/Unknown

Liver enzyme levels at time of diagnosis:

ALT (SGPT) results:

Upper limit normal:

Date of ALT:

ALT (SGOT) results:

Upper limit normal:

Date of AST:

Patient co-infected with:
☐ HIV/AIDS
☐ None
☐ HCV

Was patient hospitalized for hepatitis B or delta hepatitis?

☐ Yes ☐ No ☐ Unknown

Admission Date:

Discharge Date:

Patient's Chart Number:

Facility Type: --Select--

Facility:

Street Address:

City:

State: --Select State--

Zip:

Phone Number:

Did patient die from hepatitis? ☐ Yes ☐ No ☐ Unknown

Date:

Section 3: Diagnosis

Please select one:

- ☐ Acute Hepatitis B
- ☐ Chronic Hepatitis B
- ☐ Perinatal Hepatitis B Infection (Complete Perinatal Hepatitis B Case Investigation)
- ☐ Delta Hepatitis Infection
- ☐ Unable to Locate
- ☐ Not a Case
- ☐ False Positive
- ☐ Other

Patient education, contact follow-up, and vaccination will be done by:

☐ Local Health Department ☐ Health Care Provider ☐ Other

Specify:

Section 4: Acute Risk Factors

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

1. Live, work, or visit a nursing home or long-term care residential facility?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Address:	Contact Name:	Contact Phone:

2. Regardless of patient's gender list the number of sexual partners:

Males: Females:

☐ None ☐ Unknown

3. Did the patient inject drugs not prescribed by doctor (street drugs,steroids,hormones,vitamins,salon/spa injections)?

☐ Yes ☐ No ☐ Unknown

4. Did the patient use street drugs but not inject?

☐ Yes ☐ No ☐ Unknown

5. Did the patient undergo hemodialysis?

☐ Yes ☐ No ☐ Unknown

Date:

6. Did the patient have an accidental stick or puncture with a needle or other object (razor,clippers) contaminated with blood?

☐ Yes ☐ No ☐ Unknown

Date:

7. Did the patient receive blood or blood products (transfusion)?

☐ Yes ☐ No ☐ Unknown

Date:

8. Did the patient receive any IV infusions/blood transfers and/or injections in an outpatient setting?

☐ Yes ☐ No ☐ Unknown

Date:

Section 4: Acute Risk Factors (continued)

9. Did the patient have any outpatient procedures (i.e. endoscopy, colonoscopy, etc.)?

☐ Yes ☐ No ☐ Unknown

Type:	Facility Location:	Date:

10. Did the patient have exposure to someone else's blood?

☐ Yes ☐ No ☐ Unknown

Specify:

Date:

11. Did the patient have dental work or oral surgery?

☐ Yes ☐ No ☐ Unknown

Provider:

Date:

12. Did the patient have surgery (other than oral surgery)?

☐ Yes ☐ No ☐ Unknown

Surgeon:

Date:

13. Was the patient hospitalized overnight for any reason?

☐ Yes ☐ No ☐ Unknown

Hospital:

Date:

14. Was the patient ever incarcerated for longer than 24 hours?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Address:	Contact Name:	Contact Phone:

15. Did the patient have any part of his/her body pierced (other than ear)?

☐ Yes ☐ No ☐ Unknown

Where performed:

Date:

16. Did the patient have an ear pierced?

☐ Yes ☐ No ☐ Unknown

Where performed:

Date:

Section 4: Acute Risk Factors (continued)

17. Did the patient have a tattoo placement?

☐ Yes ☐ No ☐ Unknown

Where performed:

Date:

18. Was the patient ever employed as a healthcare worker with direct contact with human blood?

☐ Yes ☐ No ☐ Unknown

Frequency contacting blood:

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

☐ Yes ☐ No ☐ Unknown

Frequency contacting blood:

20. Was the patient ever a contact of a person with confirmed or suspected acute or chronic hepatitis B infection?

☐ Yes ☐ No ☐ Unknown

Name:	Relationship:	Phone:	Date:

Section 5: Lifetime Risk Factors

1. Was the patient ever treated for a sexually transmitted disease?

☐ Yes ☐ No ☐ Unknown

Last Treatment Date:

2. Was the patient ever incarcerated for longer than 6 months duration?

☐ Yes ☐ No ☐ Unknown

Length of Incarceration:

Date:

Section 6: Vaccine Information

1. Did the patient ever receive hepatitis B vaccine?

☐ Yes ☐ No ☐ Unknown

Date:	Vaccine Type:	Manufacturer:	Lot Number:	Physician/Institution:

2. Was the patient tested for hepatitis B antibody (anti-HBs) within 1-2 months after last dose?

☐ Yes ☐ No ☐ Unknown

Result:

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Section 7: Comments

Interviewee:	--Select--
Specify:	
Interviewee's Name:	
Submitted by Agency:	
Investigator:	
Street Address:	
City:	
State:	--Select State--
Zip:	
Phone Number:	