



**NEW HAMPSHIRE HEPATITIS B
CASE REPORT FORM
HEALTH CARE PROVIDER
Complete and fax to (603) 271-0545**

Patient's Name _____ (Last Name) _____ (First Name)
 Date of Birth _____ Age _____ Male Female Unknown
 Address _____
 City / Town _____ County _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Deceased Hospitalized (If yes, where _____)
 Occupation: _____

Report Date _____
Race
 White
 African American
 Asian
 Hawaiian or Pacific Islander
 Native Am./Alaskan Native
 Other
 Unknown
Ethnicity
 Hispanic
 Not Hispanic
 Unknown

SYMPTOMS AND SIGNS OF CURRENT EPISODE (Please answer each question)

Is this person being diagnosed with Acute Hepatitis B? Yes No
 If yes, date of diagnosis _____ Date of onset of first symptoms _____

Laboratory Results:

Hepatitis B Surface antigen (**HbsAg**)..... Positive Negative Unknown
 Hepatitis B surface antibody (**Anti-HBs**)..... Positive Negative Unknown
 Hepatitis B core antibody (**Anti-HBc**)..... Positive Negative Unknown
 Hepatitis B core antibody IgM (**IgM anti-HBc**)..... Positive Negative Unknown
 Hepatitis Be antigen (**HBe Ag**)..... Positive Negative Unknown
 Jaundice or serum ALT level >200..... Yes No Unknown

CLINICAL INFORMATION

Acute illness with a discrete onset of symptoms?..... Yes No Unknown
 Other clinical: _____
 Is the patient pregnant?..... Yes No Unknown
 Expected due date: _____ Hospital _____

HEALTH CARE PROVIDER REPORTING INFORMATION:

Reported by _____
 Health Care Provider _____ Phone _____
 Provider Facility _____
 City/Town _____ State _____ Zip _____

Mail or Fax to:
 NH Department of Health and Human Services
 Bureau of Infectious Disease Control
 29 Hazen Drive, Concord, NH 03301
 Fax: (603) 271-0545 Phone: (603) 271-4496

For NH DHHS Staff Only

Case Status
 Confirmed (meets CDC definitions)
 Not A Case
 Pregnant
 Out of state

Notes:

