New Hampshire Confidential Hepatitis B Provider Reporting Form

NH DIVISION OF Public Health Services
Department of Health and Human Services

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____/_____/_____

Address: _____ ☐ **No fixed address**

City/State/Zip: _____ **Pronouns:** _____

Home Phone: _____ **Cell Phone:** _____ **Primary Language:** _____

Sex Assigned at Birth
☐ Male ☐ Female

Gender Identity
☐ Male ☐ Female ☐ Trans male
☐ Trans female ☐ Other: _____

Race
☐ White ☐ Black ☐ Asian ☐ Pacific Islander
☐ American Indian ☐ Alaskan Native
☐ Other: _____ ☐ Unknown

Ethnicity
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Occupation/Employment

_____

Country of Birth
☐ United States
☐ Other: _____

Diagnosis date: _____/_____/_____

Is the patient aware of the diagnosis? ☐ Yes ☐ No

Is the patient pregnant? ☐ Yes ☐ No
Expected Delivery Hospital: _____

Pregnancy Test Date: _____/_____/_____
Expected Due Date: _____/_____/_____

Symptom onset date: ____/____/____

☐ Asymptomatic ☐ Jaundice ☐ Other: _____

Test Type	Test Date	Result
☐ Hepatitis B surface antigen (HBsAg)	_____/_____/_____	☐ Positive ☐ Negative
☐ Hepatitis Be antigen (HBe Ag)	_____/_____/_____	☐ Positive ☐ Negative
☐ Hepatitis B core antibody (Anti-HBc)	_____/_____/_____	☐ Positive ☐ Negative
☐ Hepatitis B core antibody IgM (IgM anti-HBc)	_____/_____/_____	☐ Positive ☐ Negative
☐ Hepatitis B DNA	_____/_____/_____	☐ Positive ☐ Negative
☐ Total Bilirubin	_____/_____/_____	_____mg/dL
☐ Peak serum alanine aminotransferase (ALT)	_____/_____/_____	_____IU/L

Does the patient have another diagnosis which more likely explains their symptoms and/or liver function? ☐ Yes ☐ No
Did the patient have a negative HBsAg test within the 12 months prior to first positive result? ☐ Yes ☐ No

Treatment status: ☐ Referred for follow-up care ☐ Diagnosing provider will treat ☐ No treatment plan at this time ☐ Infection cleared

☐ Other:_____

Contextual Factors (check all that apply)

Injection drug use	☐ Within 6 months ☐ Lifetime ☐ Denies ☐ Not asked
Non-injection illicit drug use	☐ Within 6 months ☐ Lifetime ☐ Denies ☐ Not asked
Incarceration	☐ Current ☐ Ever ☐ Never ☐ Not asked
Occupational exposure to blood	☐ Yes ☐ No ☐ Not asked
Tattoo (prison, home, or non-professional)	☐ Yes ☐ No ☐ Not asked
Long-term hemodialysis	☐ Yes ☐ No ☐ Not asked
Blood transfusion prior to 1992	☐ Yes ☐ No ☐ Not asked
Organ transplant prior to 1992	☐ Yes ☐ No ☐ Not asked
Clotting factor concentrates prior to 1987	☐ Yes ☐ No ☐ Not asked
Household contact to person with HBV	☐ Yes ☐ No ☐ Not asked
Sexual contact to person with HBV	☐ Yes ☐ No ☐ Not asked

Has the patient ever had sexual contact with (check all that apply): ☐ Men ☐ Women ☐ Transgender persons ☐ Not asked

Date of last HIV test: _____/_____/_____ ☐ Positive ☐ Negative ☐ Unknown History

Diagnosing Provider: _____ **Facility:** _____ **City/State:**_____

Person Reporting: _____ **Phone:** _____ **Date:** _____/_____/_____ ***Version 4/2024***

Fax completed forms to: 603-696-3017

Additional Forms available at: http://bit.ly/NH_Inf_Dis_Reporting

NH RSA 141-C and He-P300 mandates reporting of viral hepatitis C, newly diagnosed infections only, all physicians and health care providers. We request prompt reporting of suspect and confirmed cases within 72 hours of diagnosis. All reports are handled under strict confidentiality standards.