NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

New Hampshire Confidential Hepatitis B Provider Case Report Form

(New Diagnoses and Perinatal Exposures Only)

Date of Report:____/____/_____

Hepatitis B Being Reported: ☐ Acute ☐ Chronic ☐ Unknown ☐ Perinatal Exposure

Patient Information

Name_____
(Last) (First) (M.I.)

Date of Birth____/____/_____ Age_____ Sex: ☐ Male ☐ Female ☐ Other

Address_____City/Town_____State_____Zip _____

Phone: Cell_____Home_____Work _____

Occupation/Employment_____Healthcare Worker: ☐ Yes ☐ No ☐ Unknown

Is the patient a residence of a long-term care facility? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Native Am./Alaskan Nat ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Country of Birth: ☐ United States ☐ Other (specify) _____ ☐ Unknown

Is the patient <u>pregnant</u>? ☐ Yes ☐ No ☐ Unknown

If yes: Pregnancy Test Date:____/____/_____ Expected Due Date:____/____/_____

Expected Delivery Hospital: _____

Is this the <u>first</u> time this patient has ever been diagnosed with hepatitis B? ☐ Yes ☐ No ☐ Unknown

Diagnosis Date:____/____/_____ Is the patient aware of diagnosis? ☐ Yes ☐ No ☐ Unknown

Symptoms

☐ Asymptomatic (no symptoms) ☐ Symptomatic Symptom Onset Date:____/____/_____

☐ Fever ☐ Malaise ☐ Nausea ☐ Abdominal Pain ☐ Diarrhea

☐ Headache ☐ Anorexia ☐ Vomiting ☐ Jaundice ☐ Other: _____

Hepatitis B Testing

Tests Performed	Positive	Negative	Not Done	Unknown	Date
☐ Hepatitis B surface antigen (HBsAg)	☐	☐	☐	☐	____/____/__
☐ Hepatitis B surface antibody (Anti-HBs)	☐	☐	☐	☐	____/____/__
☐ Hepatitis B core antibody (Anti-HBc)	☐	☐	☐	☐	____/____/__
☐ Hepatitis B core antibody IgM (IGM anti-HBc)	☐	☐	☐	☐	____/____/__
☐ Hepatitis Be antigen (HBe Ag)	☐	☐	☐	☐	____/____/__
☐ Serum ALT level > 100	☐	☐	☐	☐	____/____/__

Risk Factors/Reason for Testing (check all that apply)

Year of birth 1945-1965 (i.e. "baby boomer")	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Tattoo (prison, home or non-professional)	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Employed in medical/dental/public safety or other field involving direct contact with blood	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Incarceration	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Non-injection illicit drug use	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Injection drug use, ever, even if only one time	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Injection drug use, currently using or within last 6 months	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Long term hemodialysis	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Blood transfusion prior to 1992	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Organ transplant prior to 1992	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Clotting factor concentrates produced prior to 1987	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Household contact of a person who had hepatitis B	☐ Yes	☐ No	☐ Not asked	☐ Unknown
Sexual contact with a person who had hepatitis B	☐ Yes	☐ No	☐ Not asked	☐ Unknown

Has the patient ever had sexual contact with (check all that apply):

☐ Males ☐ Females ☐ Transgender ☐ Unknown

If no risk factors listed above:

Has patient had a medical procedure (e.g. surgery, colonoscopy, etc.) or hospital stay within the last 6 months?

☐ Yes ☐ No ☐ Unknown

If yes, Type:_____ Location:_____ Date:____/____/_____

Health Care Provider Referral Information

Has this patient been referred to another healthcare provider for follow-up care? ☐ Yes ☐ No ☐ Unknown

If yes, what type of specialist: ☐ Infectious Disease ☐ Gastroenterologist ☐ Other: _____

Referral Provider Name_____ Phone_____

Referral Provider Facility/Practice Name _____

City/Town_____ State_____ Zip _____

Health Care Provider Reporting Information

Person Completing Report Form _____

Ordering Provider_____ Phone_____

Provider Facility/Practice Name _____

City/Town_____ State_____ Zip _____

Fax to: (603) 696-3017
NH Department of Health and Human Services
Bureau of Infectious Disease Control
Office Phone: 603-271-4496

For NH DHHS Use Only

- ☐ **Acute:** ☐ Confirmed ☐ Probable
- ☐ **Chronic:** ☐ Confirmed ☐ Probable
- ☐ **Unknown**
- ☐ **Perinatal Exposure**
- ☐ **Not a case of any type of hepatitis B**

☐ **Entered in NHEDSS** ☐ **Assigned to Investigator**