Massachusetts Department of Public Health
Bureau of Communicable Disease Control
Office of Integrated Surveillance and Informatics Services
305 South Street, Jamaica Plain MA 02130
*Phone: **617-983-6801** Confidential Fax: **617-983-6813***

Received in ISIS:

SUPPLEMENT #3
ACUTE HEPATITIS B REPORTING FORM

For assistance filling out this form, call (617) 983-6800

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____

CLINICAL INFORMATION

Diagnosis date: _____/_____/_____

Was case hospitalized? ☐ Yes ☐ No ☐ Unk Date hospitalized:_____/_____/_____
Hospital name: Date discharged: _____/_____/_____

Test type	Performed	Collection Date	Interpretation	Result Value	Reference Range
ALT (SGPT)	☐ Yes ☐ No ☐ Unk	___/____/____	☐ Above normal range ☐ Below normal range ☐ Normal range ☐ Unk		
AST (SGOT)	☐ Yes ☐ No ☐ Unk	___/____/____	☐ Above normal range ☐ Below normal range ☐ Normal range ☐ Unk		

INFORMATION RELEVANT TO EXPOSURE, CONTROL AND PREVENTION

In the 6 months before symptom onset:

Did the case receive blood or blood products (transfusion), organs or tissues? ☐ Yes ☐ No ☐ Unk
If **yes,** type: _____ Date(s): ____/____/____

Was the case employed in a medical or dental field involving direct contact with human blood or other potentially infectious material? ☐ Yes ☐ No ☐ Unk

Has the case received hemodialysis? ☐ Yes ☐ No ☐ Unk If **yes,** specify date(s): ____/____/____

Did the case have an accidental stick/puncture with a contaminated needle or other sharp object contaminated with blood? ☐ Yes ☐ No ☐ Unk If **yes,** specify date(s): ____/____/____

Did the case receive any IV fluids or medications and/or injections in the outpatient setting? ☐ Yes ☐ No ☐ Unk
If **yes**, specify date(s): ____/____/____

Did the case have other exposure to someone else's blood? ☐ Yes ☐ No ☐ Unk
If **yes,** please specify: _____

Did the case have surgery (other than oral surgery)? ☐ Yes ☐ No ☐ Unk If **yes**, specify date(s): ____/____/____

Did the case have dental work or oral surgery? ☐ Yes ☐ No ☐ Unk If **yes**, specify date(s): ____/____/____

Was the case hospitalized for any reason? ☐ Yes ☐ No ☐ Unk If **yes**, specify date(s): ____/____/____

Was the case a resident in a supervised care setting? ☐ Yes ☐ No ☐ Unk
If **yes**: ☐ Long-term care facility ☐ Other Date(s): ____/____/____ to ____/____/____

Did the case inject drugs not prescribed by a doctor? ☐ Yes ☐ No ☐ Unk

Please complete page 2. Include additional lab information if available.

Did the case use any drugs (not injection) not prescribed by a doctor? ☐ Yes ☐ No ☐ Unk

Was the case a sexual contact of a confirmed or suspected acute or chronic hepatitis B case? ☐ Yes ☐ No ☐ Unk
How many different male sexual partners has the case had? ☐ 0 ☐ 1 ☐ 2-10 ☐ 11+ ☐ Unk
How many different female sexual partners has the case had? ☐ 0 ☐ 1 ☐ 2-10 ☐ 11+ ☐ Unk

Is the case a household (non-sexual) contact of a confirmed or suspected hepatitis B case? ☐ Yes ☐ No ☐ Unk

Was the case employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood or other potentially infectious material? ☐ Yes ☐ No ☐ Unk

Did the case have any part of their body pierced (other than ear)? ☐ Yes ☐ No ☐ Unk
If **yes,** where was the piercing performed? (check all that apply)
☐ Commercial parlor/shop ☐ Correctional Facility ☐ Other: _____

Did the case receive a tattoo? ☐ Yes ☐ No ☐ Unk
If **yes,** where was the tattooing performed? (check all that apply)
☐ Commercial parlor/shop ☐ Correctional Facility ☐ Other: _____

Was the case incarcerated for longer than 24 hours? ☐ Yes ☐ No ☐ Unk
If **yes**, specify date(s): ____/____/____ to ____/____/____

Was the case treated for a sexually-transmitted disease? ☐ Yes ☐ No ☐ Unk

All household and sexual contacts of a confirmed hepatitis B case should receive a three dose series of hepatitis B vaccine. Please attach a list of names, ages, relationship to case and dates when administered.

ADMINISTRATIVE INFORMATION

Comments:_____
_____

Investigator's name: _____ Phone: (____) _____ - _____
Agency: _____ Fax: (____) _____ - _____
Date first reported to you: _____/_____/_____ Date form completed: _____/_____/_____

(Leave this section blank for state health department use)

Case report reviewed by epidemiologist? ☐ Yes Name: _____ Date reviewed: ___/___/_____

Import Status: ☐ Unk ☐ Acquired in Massachusetts ☐ Acquired in USA outside MA what state? _____ ☐ Acquired outside USA what country? _____

Is case part of a current outbreak? ☐ Yes ☐ No ☐ Unk Outbreak name:_____

ATTACH ORIGINAL HEPATITIS B CASE REPORT FORM