

**North Carolina Department of Health and Human Services  
Division of Public Health • Epidemiology Section  
Communicable Disease Branch**



**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department  
Communicable Disease Control  
414 East Main Street  
Durham, NC 27701

Telephone: (919) 560-7600  
Fax: (919) 560-7716

**HEPATITIS B, CHRONIC CARRIER**  
Confidential Communicable Disease Report—Part 2  
NC DISEASE CODE: 115

**REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.**

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

**NC EDSS LAB RESULTS** Verify if lab results for this event are in NC EDSS. If not present, enter results.

LABORATORY TESTING: Laboratory test results to support hepatitis B case definition. Give details below.

Collection Date	Result Date	Type of Test	Results (include serogroup/type)	Reference Range	Lab name—City/State
		<b>IgM anti-HAV</b> (IgM antibody to hepatitis A virus)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>HBs Ag</b> (Hepatitis B surface antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>anti-HBs</b> (Hepatitis B surface antibody)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>Total anti-HBc</b> (Total antibody to hepatitis B core antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>IgM anti-HBc</b> (IgM antibody to hepatitis B core antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>HBe Ag</b> (Hepatitis B e antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>Anti-HBe</b> (Antibody to hepatitis B e antigen)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
		<b>Hepatitis B DNA</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		

**NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE**

Is/was patient symptomatic for this disease? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U If yes, symptom onset date (mm/dd/yyyy): ___/___/___ CHECK ALL THAT APPLY: Fatigue or malaise or weakness ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Loss of appetite (anorexia) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Weight loss with illness ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Headache ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Joint pains (arthralgias) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Arthritis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Muscle aches/pains (myalgias) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Nausea ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Vomiting ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Abdominal pain or cramps ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Right upper quadrant pain ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Diarrhea ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Enlarged liver (hepatomegaly) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Hepatitis (inflamed liver) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Chronic Active Hepatitis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Cirrhosis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Elevated liver enzymes ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U AST Level _____ Date _____ ALT Level _____ Date _____	Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Onset date (mm/dd/yyyy): _____ Dark urine (bilirubinuria) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Onset date (mm/dd/yyyy): _____ Acute liver failure ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Hepatocellular carcinoma ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Cholecystitis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Pancreatitis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
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Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

**NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)**

**Why was the patient tested for this condition?**  
 Check all that apply:

Symptoms of acute hepatitis

Screening of asymptomatic person with reported risk factor(s)

Screening of asymptomatic person with no risk factor(s)

Prenatal screening

Evaluation of elevated liver enzymes

Blood / organ / tissue donor screening

Follow-up for previous marker for viral hepatitis

Follow-up of acute HBV

Follow-up of HBV carrier status

Blood / body fluid exposure

Household contact to a person reported with this disease

Sexual contact to a person reported with this disease

Refugee

Infant born to HBsAg positive woman

Other, specify: \_\_\_\_\_

Unknown

**PREGNANCY**

Is the patient currently pregnant?  Yes  No

Estimated delivery date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Required if currently pregnant)

For the pregnancy listed above enter the following information:

Date of Delivery or Pregnancy Termination \_\_\_\_/\_\_\_\_/\_\_\_\_

Pregnancy Outcome

Live Single Birth

Live Multiple Birth

Still Birth/ Fetal Death/ Fetal Demise (≥ 20 weeks gestation)

Miscarriage/Spontaneous Abortion (< 20 weeks gestation)

Elective Abortion

Has this person given birth in the last 24 months? (Other than pregnancy listed above)  Yes  No

For each live birth in the last 24 months please record the following information:

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Has this infant been entered in NC EDSS as a Hepatitis B perinatal contact?  Yes  No

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Has this infant been entered in NC EDSS as a Hepatitis B perinatal contact?  Yes  No

**HOSPITALIZATION INFORMATION**

**Was patient hospitalized for this illness?** .....  Y  N  U

1. Hospital name: \_\_\_\_\_

City, State: \_\_\_\_\_

Hospital contact name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Admit date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Discharge date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

**If applicable:**

2. Hospital name: \_\_\_\_\_

City, State: \_\_\_\_\_

Hospital contact name: \_\_\_\_\_

Phone: \_\_\_\_\_

Admit date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Discharge date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Notes:**

**ISOLATION/QUARANTINE/CONTROL MEASURES**

**Restrictions to movement or freedom of action?** .....  Y  N  U

Check all that apply:

Work  Sexual behavior

Child care  Blood and Body Fluid

School  Other

Date control measures issued: \_\_\_\_\_

Date control measures ended: \_\_\_\_\_

Was patient compliant with control measures? .....  Y  N  U

**Were written isolation orders issued?..**  Y  N  U

If yes, where was the patient isolated? \_\_\_\_\_

\_\_\_\_\_

Date isolation started? \_\_\_\_\_

Date isolation ended? \_\_\_\_\_

Was the patient compliant with isolation? .....  Y  N  U

**Were written quarantine orders issued?** .....  Y  N  U

If yes, where was the patient quarantined? \_\_\_\_\_

\_\_\_\_\_

Date quarantine started? \_\_\_\_\_

Date quarantine ended? \_\_\_\_\_

Was the patient compliant with quarantine?.....  Y  N  U

**CLINICAL OUTCOMES**

**Discharge/Final diagnosis:** \_\_\_\_\_

\_\_\_\_\_

**Survived?** .....  Y  N  U

**Died?**.....  Y  N  U

**Died from this illness?**.....  Y  N  U

Date of death (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**TRAVEL/IMMIGRATION**

**The patient is:**

Resident of NC

Resident of another state or US territory

Foreign Visitor

Refugee

Recent Immigrant

Foreign Adoptee

Other, specify: \_\_\_\_\_

**Notes:**

**CHILD CARE/SCHOOL/COLLEGE**

**Patient in child care?** .....  Y  N  U

Name of child care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

**Notes:**

**HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS**

**During the six months prior to positive serology (HBsAg, HBeAg, or HBV DNA) until negative HBsAg, did the patient have any of the following risks:**

Dental or oral surgery? .....  Y  N  U

Dialysis? .....  Y  N  U

Hospitalization? .....  Y  N  U

Reside in a long term care facility?.....  Y  N  U

Employment in a medical/dental field involving direct contact with human blood?.....  Y  N  U

Did someone else have exposure to patient's blood? .....  Y  N  U

Specify: \_\_\_\_\_

Give details for all "yes" responses above:

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						SSN / /

**BEHAVIORAL RISK & CONGREGATE LIVING**

During the six months prior to positive serology (HBsAg, HBeAg, or HBV DNA) until negative HBsAg did the patient live in any congregate living facilities such as correctional facilities, dormitories, sororities, fraternities, barracks, camps, commune, boarding school, shelter etc?  Y  N  U

Facility: \_\_\_\_\_  
 College or University: \_\_\_\_\_  
 City: \_\_\_\_\_  
 County: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Phone Number: (\_\_\_\_) \_\_\_\_\_  
 Date of contact: \_\_\_\_\_

During the six months prior to positive serology (HBsAg, HBeAg, or HBV DNA) until negative HBsAg, did the patient have any of the following risks:

Receive a tattoo?  Y  N  U

Where was tattooing performed?

- Commercial parlor/shop
- Correctional facility
- Other, specify: \_\_\_\_\_
- Unknown

Receive body piercing?  Y  N  U

Specify: \_\_\_\_\_

Ear piercing?  Y  N  U

Where was ear piercing performed?

- Commercial parlor/shop
- Correctional facility
- Other, specify: \_\_\_\_\_
- Unknown

Piercing other than ear?  Y  N  U

Where was that piercing performed?

- Commercial parlor/shop
- Correctional facility
- Other, specify: \_\_\_\_\_
- Unknown

Inject drugs not prescribed by a doctor?  Y  N  U

Have sexual contact with a person who was confirmed/suspected of having acute or chronic hepatitis B virus infection?  Y  N  U

Specify number of partners:  
 1  2-5  >5  U

Have sexual contact with a FEMALE?  Y  N  U

Number of female sex partners:  
 1  2-5  >5  U

Have sexual contact with a MALE?  Y  N  U

Number of male sex partners:  
 1  2-5  >5  U

**VACCINES**

Has patient ever received hepatitis B vaccine?  Y  N  U

Specify type:

- Vaccine Type Known: \_\_\_\_\_
- Vaccine Type Unknown (NOS)

How many shots? (1/2/3+): \_\_\_\_\_

In what year was last dose received? (YYYY): \_\_\_\_\_

Dates of hepatitis B vaccine:

(mm/dd/yyyy): \_\_\_\_\_

(mm/dd/yyyy): \_\_\_\_\_

(mm/dd/yyyy): \_\_\_\_\_

(mm/dd/yyyy): \_\_\_\_\_

Vaccination dates unknown

NOTES:

**CASE INTERVIEWS/INVESTIGATIONS**

Was the patient interviewed?  Y  N  U

Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Were interviews conducted with others?  Y  N  U

Who was interviewed?

Were health care providers consulted?  Y  N  U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)?  Y  N  U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

**GEOGRAPHICAL SITE OF EXPOSURE**

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

- In NC  
 City \_\_\_\_\_  
 County \_\_\_\_\_
- Outside NC, but within US  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 County \_\_\_\_\_
- Outside US  
 City \_\_\_\_\_  
 Country \_\_\_\_\_
- Unknown

Is the patient part of an outbreak of this disease?  Y  N

Notes regarding setting of exposure:

# Chronic Hepatitis B Virus

## 2007 CDC Case Definition

### Clinical description

Persons with chronic HBV infection may have no evidence of liver disease or may have a spectrum of disease ranging from chronic hepatitis to cirrhosis or liver cancer. Persons with chronic infection may be asymptomatic.

### Laboratory criteria for diagnosis

- IgM antibodies to hepatitis B core antigen (anti-HBc) negative AND a positive result on one of the following tests: hepatitis B surface antigen (HBsAg), hepatitis B e antigen (HBeAg), or hepatitis B virus (HBV) DNA

### OR

- HBsAg positive or HBV DNA positive or HBeAg positive two times at least 6 months apart (Any combination of these tests performed 6 months apart is acceptable.)

### Case classification

*Confirmed:* a case that meets either laboratory criteria for diagnosis

*Probable:* a case with a single HBsAg positive or HBV DNA positive or HBeAg positive lab result when no IgM anti-HBc results are available