New Jersey Department of Health  
Vaccine Preventable Diseases Program  
HEPATITIS B CASE REPORT

Instructions to Health Care Provider:
Hepatitis B, a communicable disease, is reportable to the New Jersey Department of Health under the New Jersey Administrative Code (NJAC) 8:57. Please note that the Health Insurance Portability and Accountability Act (HIPAA) expressly permits disclosures without individual authorization to public health authorities authorized by law to receive information for the purpose of preventing or controlling communicable disease.

Given the complexity of the hepatitis B disease case definition and the various serologic laboratory results, additional information is needed by public health officials to determine the patient’s case status. Additionally, the pregnancy status must be obtained for any HBsAg positive female age 15 to 45 years.

Your assistance is needed to determine the case status of the following patient. Please complete and return this form to the sender.

### DEMOGRAPHICS

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**RACE (check all that apply):**
- American Indian or Alaska Native
- Black or African American
- White
- Asian
- Native Hawaiian or Pacific Islander
- Other, specify:

**ETHNICITY (check all that apply):**
- Hispanic
- Non-Hispanic
- Other/Unknown

**SEX:**
- Male
- Female
- Unknown

**BIRTHDATE:**

**PLACE OF BIRTH:**
- USA
- Other:

**Hepatitis B Vaccination History?**
- Yes
- No
- Unknown

**NJIS ID (if applicable):**

**Dose 1:**

**Dose 2:**

**Dose 3:**

**For Females 15-45 Years of Age: PREGNANT?**
- Yes
- No
- Unknown

If YES, Estimated Delivery Date:

**Intended Delivery Site (if known):**

### CLINICAL AND DIAGNOSTIC DATA

**SYMPTOMS (check all that apply):**
- Asymptomatic
- Abdominal pain/cramps
- Malaise
- Nausea
- Vomiting
- Arthralgia
- Fever
- Clay-colored stool
- Liver abnormalities
- Cirrhosis
- Anorexia
- Dark urine
- Loss of appetite
- Rash
- Elevated liver enzymes*
- Jaundice
- Other, specify:

**REASON FOR TESTING (check all that apply):** *
- Screening of asymptomatic patient with no risk factors (i.e., patient request)
- Screening of asymptomatic patient with reported risk factors
- Prenatal screening
- Follow-up testing for previous marker of viral hepatitis
- Evaluation of elevated liver enzymes
- Evidence of chronic hepatitis or liver disease
- Blood/organ donor screening
- Other, specify:

* Please attach copies of all relevant testing done including serology, liver enzymes and DNA.
## Clinical and Diagnostic Data, Continued

### Clinical Diagnosis:

- [ ] Chronic hepatitis B
- [ ] Acute hepatitis B
- [ ] Perinatal hepatitis B infection
- [ ] Acute hepatitis A
- [ ] Hepatitis C infection
- [ ] Other, specify: ________________________________

**Diagnosis Date:** __/__/____

- [ ] Hospitalized for hepatitis? Yes
- [ ] No
- [ ] Unknown
- [ ] Died? Yes
- [ ] No
- [ ] Unknown

- [ ] Was the patient aware they had hepatitis prior to lab testing? Yes
- [ ] No
- [ ] Unknown

### Risk Factors

In the 6 weeks – 6 months prior to onset of symptoms, did the person **(check all that apply):**

- [ ] Have contact with a confirmed or suspected hepatitis case
- [ ] Foreign born in areas where hepatitis is endemic (where: ________________________)
- [ ] Unprotected sex
- [ ] Acupuncture
- [ ] Injection drug user
- [ ] Blood transfusion/recipient of blood products
- [ ] Perinatal exposure
- [ ] Dental procedure
- [ ] Recent hepatitis B vaccination
- [ ] Hemodialysis patient
- [ ] Hospitalization
- [ ] Tattoo/Piercing
- [ ] Injections/infusions
- [ ] Travel to high risk area
- [ ] Occupational exposure
- [ ] Organ donor/recipient
- [ ] Previous/present incarceration
- [ ] MSM
- [ ] Use of finger stick devise/phlebotomy in home/other setting
- [ ] No vaccination
- [ ] Healthcare procedure (specify: ________________________)

### Education

- [ ] Was the patient informed of diagnosis? Yes
- [ ] No

- [ ] Have patient and/or family member been counseled on mode of transmission and precautions regarding hepatitis B? Yes
- [ ] No

### Contacts

(Use additional space at the bottom if necessary)

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**Comments:**