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: _____/_____/_____

<table>
<thead>
<tr>
<th>Test type</th>
<th>Performed</th>
<th>Collection Date</th>
<th>Interpretation</th>
<th>Result Value</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT (SGPT)</td>
<td>□ Yes</td>
<td>__/<strong><strong>/</strong></strong></td>
<td>□ Above normal range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td>□ Below normal range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Unk</td>
<td></td>
<td>□ Normal range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Unk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AST (SGOT)</td>
<td>□ Yes</td>
<td>__/<strong><strong>/</strong></strong></td>
<td>□ Above normal range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td>□ Below normal range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Unk</td>
<td></td>
<td>□ Normal range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Unk</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
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**