Leeds, Grenville & Lanark District HEALTH UNIT

HEPATITIS B REPORTING FORM
EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

REPORTING SOURCE		
Name:	Agency:	
Phone #:	Date (y/m/d):	Time:

CLIENT INFORMATION		
Last Name:	First Name:	Gender:
Phone #:	DOB (y/m/d):	
Address:	City:	Postal Code:
HEALTH CARE PROVIDER:	Phone #:	Fax #:

MEDICAL RISK FACTORS (Check all that apply)	BEHAVIOURAL SOCIAL RISK FACTORS (Check all that apply)
☐ Born to case or carrier ☐ Pregnant	☐ Contact is Hep B positive
☐ Received blood or blood products	☐ Inhalation Drug Use ☐ Injection Drug Use
Location & Date:	☐ Sex with multiple partners in last two years
☐ Invasive Surgical / Dental / Ocular Procedures	☐ Sexual contact in past 2 months
Location & Date:	☐ Unprotected sex
☐ Organ/tissue transplant	☐ Blood Exposure (fighting, accident)
Location & Date:	☐ Shared personal items (toothbrush, razor)
☐ Dialysis Recipient	☐ Electrolysis/Acupuncture ☐ Other personal services
☐ Co-infection with existing STI	☐ Travel or live in endemic country
☐ Not immunized	☐ Incarceration

IMMUNIZATION HISTORY

Patient is eligible for free Hepatitis A vaccine if not immune.

See Reportable Disease Toolkit at http://www.healthunit.org/professionals/rd_toolkit/Reportable_Diseases.pdf for vaccine order form.

Did patient receive HBIG prior to diagnosis: ☐ Yes ☐ No If yes, date: (YYYY/MM/DD) / /

Has client received Hepatitis B immunization: ☐ YES ☐ NO	Has client received Hepatitis A immunization: ☐ YES ☐ NO
HEP B #1 / #2 / #3 /	HEP A #1 / #2 /
(YYYY / MM) (YYYY / MM) (YYYY / MM)	(YYYY / MM) (YYYY / MM)

CASE DETAILS	
Date of Diagnosis (y/m/d):	Source of infection if known:

SYMPTOMS: ☐ Asymptomatic Earliest Onset Date (*except in an asymptomatic case*):

☐ Abdominal pain	☐ Nausea/vomiting	☐ Loss of appetite/weight	☐ Dark Urine
☐ Malaise/Fatigue	☐ Jaundice	☐ Generalized body aches	☐ Other:

COMPLICATIONS	
☐ Hospitalized Name of Hospital:	☐ None ☐ Cirrhosis ☐ Liver Cancer
Admitted: (Y/M/D) / / Discharged: (Y/M/D) / /	

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CASE MANAGEMENT (Refer to Primary Care Management of Hepatitis B-Quick Reference http://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-82-2013-eng.pdf for patient education and counselling.)

Is patient aware of Hepatitis B: ☐ **YES** ☐ **NO**

Has patient been referred to a liver specialist: ☐ YES ☐ NO If yes, where has your patient been referred?

If not, will you be referring patient: ☐ YES ☐ NO

Treatment: ☐ YES ☐ NO Date: (YYYY/MM/DD): / /

Have you counselled, or do you plan to counsel your patient re: transmission prevention and the disease process: ☐ YES ☐ NO

Would you like the Health Unit nurse to provide further information to the patient: ☐ YES ☐ NO

CONTACT MANAGEMENT

Contacts include: Household members, persons who share personal care items (i.e. razors, tooth brushes), sexual contacts, persons exposed to infected blood, or body fluids, infants born to HBV infected mothers.

Please provide as much detail as possible. **Contacts are eligible for free Hepatitis B vaccine if not immune.**

Fill out vaccine order form @ https://healthunit.org/wp-content/uploads/Eligible_Hep_AB_Vaccine_Order_Form.pdf

NAME & RELATIONSHIP	DOB (YY / MM / DD)	PHONE NUMBER / ADDRESS	NOTIFIED		IMMUNE STATUS TEST RESULTS	DATES OF VACCINATIONS (YY / MM / DD)
	/ /		☐ YES	☐ NO		/ /
						/ /
						/ /
	/ /		☐ YES	☐ NO		/ /
						/ /
						/ /
	/ /		☐ YES	☐ NO		/ /
						/ /
						/ /
	/ /		☐ YES	☐ NO		/ /
						/ /
						/ /
	/ /		☐ YES	☐ NO		/ /
						/ /
						/ /

Form completed by:	Date:

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7.