Enhanced Hepatitis B Case Investigation Form

Instructions:

Healthcare professionals (HCPs) have a legislative duty to report notifiable and reportable diseases to the Chief Public Health Officer (CPHO) as required in the NWT *Public Health Act* (2009, SNWT 2007, c.17, SI-007-2009), with required information and timelines for reporting as defined in the *Disease Surveillance Regulations* (2009, R-096-2009). This information is used for territorial and national surveillance and informs public health planning and interventions. This reporting by the HCPs is accomplished by submitting this form to the Office of the Chief Public Health Officer (OCPHO). Information on cases of the following diseases is reportable within specific time frames:

	Timeline for submitting *Case Investigation Form* to OCPHO after making a diagnosis or opinion	**Sections of *Case Investigation Form* to complete**
Hepatitis B	24 hours	All (Sections 1-8) and contact tracing form (Section 9)

In addition to case information, HCPs shall make reasonable efforts to initiate contact tracing within 24 hours of a reportable disease diagnosis and provide the OCPHO with information respecting the contact tracing and specific control measures that have been initiated or are being carried out, as outlined the *Reportable Disease Control Regulations* (R-128-2009).

What to Report

Hepatitis B

- For Part 2 written report within 24 hours:
  - Confirmed and probable cases are to be reported to the Office of the Chief Public Health Office (OCPHO) within **24 hours** after diagnosis is made or opinion is formed by completing the Enhanced Hepatitis B Case Investigation Form then submitting to Communicable Disease Control Unit (CDCU) via secure medical fax 867-873-0442 or Secure File Transfer CDCU@gov.nt.ca.
  - If there are any updates regarding the case or contacts the appropriate form will need to be resent with the additional information
  - **Immediately** report all outbreaks or suspect outbreaks by telephone (867)-920-8646 to the OCPHO

Contact information

- Who to identify as a contact and the advice given will vary for the reportable disease as outlined in the respective Communicable Disease Manual chapter.

Important!

An enhanced hepatitis B case investigation and contact tracing form, even if not fully complete, must still be reported (submitted) to the OCPHO within the timeframes identified above. It is expected that HCPs submit an *updated* investigation and contact tracing form as new information is received.

Completed report forms (initial forms and updates) should be sent to OCPHO by
Medical Confidential Fax: 867-873-0442 or
Secure File Transfer: CDCU@gov.nt.ca

Enhanced Hepatitis B Case Investigation Form

Report is: ☐ Initial ☐ Update **New information provided on section(s):**

SECTION 1: CASE INFORMATION

Affix Label		
	Last Name:	**Gender:** ☐Male ☐Female ☐Other ☐Not Asked
	First Name:	**Sex at Birth:** ☐Male ☐Female ☐Intersex
	Date of Birth (YY/MM/DD):	**Home Community:**
	HCN (including OOT HCN):	**Province/Territory:**
	Consent to: ☐ leave voicemail messages - ☐ cell and/or ☐ home phone ☐ send text messages	
	Phone #(s):	

SECTION 2: CLASSIFICATION/DISEASE REPORTING

Classification: ☐Confirmed ☐Probable	Stage: ☐ Acute ☐ Chronic ☐ Unspecified ☐ Pending 6-month follow-up, date to follow-up ____/_____/_____/ (YY/MM/DD)

Prior Hepatitis B diagnosis? ☐Yes ☐No If yes: Region of diagnosis (P/T/Country) _____

Date of diagnosis ____/_____/_____/ (YY/MM/DD) Is the case being treated for Hepatitis B?_____

SECTION 3: SIGNS & SYMPTOMS

☐**Asymptomatic or** ☐ **Earliest Onset Date:** ____/_____/_____/ (YY/MM/DD)

Check all that apply:

Abdominal pain	Onset date: ____/_____/_____/	Fever	Onset date: ____/_____/_____/
Anorexia	Onset date: ____/_____/_____/	Jaundice	Onset date: ____/_____/_____/
Arthralgia/joint pain	Onset date: ____/_____/_____/	Malaise/fatigue	Onset date: ____/_____/_____/
Clay coloured stools	Onset date: ____/_____/_____/	Nausea/vomiting	Onset date: ____/_____/_____/
Dark urine	Onset date: ____/_____/_____/	Other:	Onset date: ____/_____/_____/

SECTION 4: REASON FOR TESTING

☐Routine Screening ☐Contact of a Case ☐Risk Factor(s) ☐Symptomatic ☐Prenatal ☐Other, specify:_____

SECTION 5: LABORATORY INFORMATION

Specimen collection date for current investigation: ____/_____/_____/ (YY/MM/DD)

☐ HBsAg, Result: _____ ☐ Anti-HBs, Result: _____ ☐ Anti-HBc IgM Result: _____

☐ Total Anti-HBc, Result: _____ ☐ HBV DNA, Result: _____ ☐ HBeAg Result: _____

Specimen collection date for 6-month follow-up: ____/_____/_____/ (YY/MM/DD)

☐ HBsAg, Result: _____ ☐ Anti-HBs, Result: _____

SECTION 6: IMMUNIZATION HISTORY

Has case received a dose of hepatitis B vaccine: ☐Yes ☐No ☐Unknown

Dose 1: ____/_____/_____/ (YY/MM/DD) Product:_____ Dose 2: ____/_____/_____/ (YY/MM/DD) Product: _____

Dose 3: ____/_____/_____/ (YY/MM/DD) Product: _____ Dose 4: ____/_____/_____/ (YY/MM/DD) Product: _____

Enhanced Hepatitis B Case Investigation Form

SECTION 7: POSSIBLE RISK BEHAVIOUR					
Please complete the following:	**Yes**	**No**	**Un-known**	**Declined to Answer**	**Not Asked**
BLOOD/TISSUE/ORGAN DONATION Is the case a recipient of a blood/blood product, tissue, or organ transplant prior to 1992 within Canada? Is the case a recipient of a blood/blood product, tissue, or organ transplant outside of Canada? Does the case have a history of donating blood, tissue, or organ(s)?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
IMMIGRATION AND TRAVEL Was the case born in, traveled to, or lived in a country with high prevalence of hepatitis b?	☐	☐	☐	☐	☐
BEHAVIOURAL Does the case inject drugs or have any history of injection drug use (IDU)? Has the case shared injection, intranasal, or inhalation drug use equipment, even once?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
SEXUAL/BLOOD-BORNE INFECTIONS Was the case a sexual contact of a known case of hepatitis B or person at high risk of hepatitis B infection (e.g., history of IDU)? Does the case have any other STBBIs or a history of STBBI infection (e.g., HIV, syphilis, etc.)?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
HOUSEHOLD CONTACT Does the case live in the same household as a known case of hepatitis B? If yes, does the case share personal care items, such as nail clippers, toothbrushes or razers with the known case?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
PERCUTANEOUS EXPOSURE Has the case ever had acupuncture, or did they get any tattoos or piercings, or scarification? Has the case ever had a non-occupational needle stick injury?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
MEDICAL EXPOSURE In any country where infection prevention control practices are not standardized, did the case have an invasive medical or dental procedure (e.g., dialysis, cosmetic surgery, etc.)?	☐	☐	☐	☐	☐
OCCUPATIONAL EXPOSURE Has the case had an occupational needlestick injury? Has the case had any occupational exposure to blood or body fluids?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
PREGNANCY Is the case pregnant? Was the case born to a mother with hepatitis B infection?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
INCARCERATION Is the case currently incarcerated or were they incarcerated in the past?	☐	☐	☐	☐	☐
Other (please specify):					

SECTION 8: REPORTING	
Clinic Site or Hospital Unit:	
Completed by:	**Signature:**
Phone:	**Date:**
Comments:	

How to submit: By Medical Confidential Fax: 867-873-0442 OR **Secure File Transfer:** to CDCU@gov.nt.ca

Enhanced Hepatitis B Case Investigation Form

CASE DEFINITIONS	
Acute Case	

Confirmed	• Laboratory confirmation of infection with clinical illness[A] or probable exposure within the last 6 months:
	  ○ Immunoglobulin M antibody to Hepatitis B core antigen (anti-HBc IgM) positive **AND** one of the following:
	  ▪ Hepatitis B surface antigen (HBsAg) positive **or**
	  ▪ HBV DNA positive
	or
	• Clearance of HBsAg within a 6-month period in a person who was documented HBsAg positive with a history of clinical illness[A] or probable exposure.

Probable	Acute clinical illness[A] in a person who is epidemiologically linked to a confirmed case (acute or chronic) and test results are unknown /unavailable
Chronic Case	

Confirmed	Laboratory confirmation of infection with or without clinical illness[A]:
	• Detection of Hepatitis B surface antigen (HBsAg) or HBV DNA or HBeAg for more than 6 months;
	or
	• Immunoglobulin M antibody to Hepatitis B core antigen (anti-HBc IgM) negative **AND** at least one of the following:
	  ○ HBsAg positive **or**
	  ○ HBV DNA positive **or**
	  ○ HBeAg positive
	or
	• Total antibody to Hepatitis B core antigen (anti-HBc total) positive and HBV DNA positive; and HBsAg negative and Antibody to Hepatitis B Surface Antigen (anti-HBs) negative

Probable	Laboratory confirmation of infection:
	• Single HBsAg positive in the context of:
	  ○ History of compatible clinical illness more than 6 months ago; **or**
	  ○ Self-reported history of Hepatitis B testing and/or diagnosis more than 6 months ago; **or**
	  ○ Born and/or lived in Hepatitis B endemic country (prevalence ≥8%) more than 6 months ago.

A. Clinical illness: a discrete onset of symptoms (e.g., fever, headache, malaise, anorexia, nausea, vomiting, abdominal pain, dark urine) and either jaundice or elevated serum aminotransferase level.

Report is: ☐ Initial ☐ Update	Index Case HCN:

MUST PRINT: HEPATITIS B CONTACT TRACING REPORT FORM

Instructions: As per the *Reportable Disease Control Regulations* (R-128-2009), HCPs shall make reasonable attempts to initiate contact tracing within 24 hours of reportable disease diagnosis. Please submit initial available contact information with the case investigation form. HCPs are also to provide the OCPHO with information respecting the contact tracing and specific control measures that have been initiated or carried out. Please submit an updated contact tracing form whenever:

1. A new contact has been identified
2. A contact has been treated

SECTION 9: PUBLIC HEALTH FOLLOW-UP

Contact Tracing

Contact of a case of (check all that apply): ☐ Hepatitis B

Affix Label		
	Last Name:	**LAST EXPOSURE TO CASE** Date (dd/mmm/yyyy):_____ Location *(NWT community or out of territory)*:_____
	First Name:	
	HCN:	**Relationship to case** *(check all that apply)*:
	Age: **Birthdate (dd/mmm/yyyy):**	☐ Sexual partner ☐ Drug-use partner ☐ Household
	Sex: ☐Male ☐Female ☐Unknown ☐Prefer not to answer	☐ Other
	Current Address:	
	Confirmed Phone Number(s):	

☐ Health care professional will follow-up with contact **OR**
☐ Contact information forwarded to _____ for follow up

Follow up information

Date contact notified (dd/mmm/yyyy): _____

Notes:

Attempt to notify contacts:

	Date	To/From	Outcome	Investigators Initials
1.				
2.				
3.				
4.				

Report date (dd/mmm/yyyy):	**Clinic name:**	**Community:**
Report completed by (print):	**Reported completed by** (signature):	

How to submit: By Medical Confidential Fax: 867-873-0442 OR **Secure File Transfer:** to CDCU@gov.nt.ca