# ENHANCED HEPATITIS B AND C - CASE INVESTIGATION

**Health Care Provider:** _____ **Date:** Y: M: D:

☐**Hepatitis B or** ☐**Hepatitis C report has been received on your patient.**

| **Name:** | HCP# |
|---|---|
| **Date of Birth:** Y: M: D: or **Age**: | |
| **Address:** | |

| **Referral to Internal Medicine:** ☐**Yes** ☐**No** | | | | |
|---|---|---|---|---|
| **Reason for Testing:** | | | | |
| Symptomatic: ☐ | High Risk Exposure: ☐ | Sexual Exposure: ☐ | Illicit Drug Use: ☐ | Maternal: ☐ |
| **Have contacts been followed** (see page #2 for list of contacts): ☐Yes ☐No | | | | |
| **Has this person donated blood?** ☐**No** ☐**Yes,** if yes, where and when was last donation?<br>Where: When: | | | | |

***Socioeconomic Factors***

| **Marital Status:** | **Education:** |
|---|---|
| ☐Life-Partner (incl. Married/ Common-Law/Same Sex Partner)<br>☐Single (incl. Widowed/Separated/Divorced) | ☐Some/All Elementary ☐Some/All High School<br>☐Some/All College/University |

| ***Employment:*** | **Type of Housing:** | | |
|---|---|---|---|
| ☐*Employed* ☐*Unemployed* ☐*Retired*<br>☐*Disability* ☐*EI/Social Assistance* | ☐Rents<br>☐Emergency Shelter<br>☐Transitional | ☐Social Housing<br>☐Home Owner<br>☐Homeless | ☐Institutionalized<br>☐Unknown |

| **Has this person been referred to:** | | |
|---|---|---|
| Addiction services: ☐*Y* ☐*N* ☐*Unk*<br>*D: M: Y:* | *Medical Social Worker:* ☐*Y* ☐*N* ☐*Unk*<br>*D: M: Y:* | *Mental Health Worker:* ☐*Y* ☐*N* ☐*Unk*<br>*D: M: Y:* |
| ***Comments:*** | | |

| Possible Risk Behaviour | YES | NO | Possible Risk Behaviour | Yes | No |
|---|---|---|---|---|---|
| 1. Men who have sex with men | | | 7. Received transfusion of whole blood or blood components* | | |
| 2. Heterosexual sex with injection drug user | | | 8. Occupational exposure to hepatitis contaminated blood or body fluids or concentrated virus | | |
| 3. Heterosexual sex with confirmed or suspected hepatitis case | | | 9. Perinatal transmission | | |
| 4. Injected non-prescription drugs (at any time in the past including steroids) | | | 10. Contact with a person who lived in an area where these diseases are prevalent | | |
| 5. Received pooled concentrates for treatment of haemophilia or coagulation disorder* | | | 11. Household contact with confirmed or suspected case of hepatitis | | |
| 6. Body piercing or tattoo | | | 12. Acupuncture, dialysis, EEG, dental, other (specify) | | |

*If yes to questions 5 and 7, please note the institution where this was given and the year:

Other Medical Issues: Present treatment: (type, list drugs, date):

Hospitalized: ☐ No ☐Yes Name of Hospital:

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| Additional Lab Results | Date | Value |
|---|---|---|
| • HBsAg | | |
| • Anti-HBs | | |
| • HCV RNA | | |
| • HIV | | |

**Contacts:** (If more space needed use contact list)

| **Name** | ***1.*** | ***2.*** | ***3.*** | ***4.*** |
|---|---|---|---|---|
| Date of Birth | | | | |
| HCP# | | | | |
| Gender | | | | |
| Relation to Patient | | | | |
| Type of Contact | | | | |
| Dates of Contact | | | | |

| Comments: |
|---|
| |
| |
| |
| |
| |

| | |
|---|---|
| **Person Reporting:** | **Title:** |
| **Place:** | **Date:** |
| **Signature:** | |

**For further information please use your NWT Communicable Disease Manual. Also available @: http://www.hlthss.gov.nt.ca/ in the publication section.**

***Please return this completed form to:***

**Office of the Chief Public Health Officer**
**Department of Health and Social Services**
**6th Floor – Centre Square Tower, PO Box 1320, Yellowknife NT X1A 2L9**
**Phone: (867) 920-8646 / Fax: (867) 873-0442**