

## CASE REPORT FORM

## Hepatitis B, C, NOS

|                                                                                                                           |  |                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| Hepatitis B, C, NOS                                                                                                       |  | EpiSurv No. _____                                                                                   |  |
| <b>Disease Name</b>                                                                                                       |  |                                                                                                     |  |
| <input type="radio"/> Hepatitis B                                                                                         |  | <input type="radio"/> Hepatitis C                                                                   |  |
|                                                                                                                           |  | <input type="radio"/> Hepatitis NOS                                                                 |  |
| <b>Reporting Authority</b>                                                                                                |  |                                                                                                     |  |
| Name of Public Health Officer responsible for case <b>OfficerName</b> _____                                               |  |                                                                                                     |  |
| <b>Notifier Identification</b>                                                                                            |  |                                                                                                     |  |
| <b>Reporting source*</b>                                                                                                  |  | <b>ReportSrc</b>                                                                                    |  |
| <input type="radio"/> General Practitioner                                                                                |  | <input type="radio"/> Hospital-based Practitioner                                                   |  |
| <input type="radio"/> Self-notification                                                                                   |  | <input type="radio"/> Outbreak Investigation                                                        |  |
|                                                                                                                           |  | <input type="radio"/> Laboratory                                                                    |  |
|                                                                                                                           |  | <input type="radio"/> Other                                                                         |  |
| Name of reporting source <b>ReportName</b> _____                                                                          |  | Organisation <b>ReportOrganisation</b> _____                                                        |  |
| Date reported* <b>ReportDate</b> _____                                                                                    |  | Contact phone <b>ReportPhone</b> _____                                                              |  |
| Usual GP <b>UsualGP</b> _____                                                                                             |  | Practice <b>GPPPracticeName</b> _____                                                               |  |
|                                                                                                                           |  | GP phone <b>GPPhone</b> _____                                                                       |  |
| GP/Practice address Number _____ Street _____ Suburb _____                                                                |  |                                                                                                     |  |
| <b>GPAAddress</b> Town/City _____                                                                                         |  | Post Code _____ <input type="checkbox"/> GeoCode _____                                              |  |
| <b>Case Identification</b>                                                                                                |  |                                                                                                     |  |
| Name of case*                                                                                                             |  |                                                                                                     |  |
| Surname <b>Surname</b> _____                                                                                              |  | Given Name(s) <b>GivenName</b> _____                                                                |  |
| NHI number* <b>NHINumber</b> _____                                                                                        |  | Email <b>Email</b> _____                                                                            |  |
| Current address*                                                                                                          |  |                                                                                                     |  |
| Number _____ Street _____ Suburb _____                                                                                    |  |                                                                                                     |  |
| <b>CaseAddress</b> Town/City _____                                                                                        |  | Post Code _____ <input type="checkbox"/> GeoCode _____                                              |  |
| Phone (home) <b>PhoneHome</b> _____                                                                                       |  | Phone (work) <b>PhoneWork</b> _____                                                                 |  |
|                                                                                                                           |  | Phone (other) <b>PhoneOther</b> _____                                                               |  |
| <b>Case Demography</b>                                                                                                    |  |                                                                                                     |  |
| Location TA* <b>TA</b> _____                                                                                              |  | DHB* <b>DHB</b> _____                                                                               |  |
| Date of birth* <b>DateOfBirth</b> _____                                                                                   |  | OR Age <b>Age</b> _____                                                                             |  |
|                                                                                                                           |  | <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years <b>AgeUnits</b> |  |
| Sex* <b>Sex</b>                                                                                                           |  |                                                                                                     |  |
| <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown |  |                                                                                                     |  |
| Occupation* <b>Occupation</b> _____                                                                                       |  |                                                                                                     |  |
| Occupation location <b>PlaceOfWork1Type</b>                                                                               |  | <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school   |  |
| Name <b>PlaceOfWork1</b> _____                                                                                            |  |                                                                                                     |  |
| Address                                                                                                                   |  |                                                                                                     |  |
| Number _____ Street _____ Suburb _____                                                                                    |  |                                                                                                     |  |
| <b>PlaceOfWork1Address</b> Town/City _____                                                                                |  | Post Code _____ <input type="checkbox"/> GeoCode _____                                              |  |
| Alternative location <b>PlaceOfWork2Type</b>                                                                              |  | <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school   |  |
| Name _____                                                                                                                |  |                                                                                                     |  |
| Address                                                                                                                   |  |                                                                                                     |  |
| Number _____ Street _____ Suburb _____                                                                                    |  |                                                                                                     |  |
| <b>PlaceOfWork2Address</b> Town/City _____                                                                                |  | Post Code _____ <input type="checkbox"/> GeoCode _____                                              |  |
| <b>Ethnic group case belongs to*</b> (tick all that apply)                                                                |  |                                                                                                     |  |
| <input type="checkbox"/> NZ European <b>EthNZEuroean</b>                                                                  |  | <input type="checkbox"/> Maori <b>EthMaori</b>                                                      |  |
|                                                                                                                           |  | <input type="checkbox"/> Samoan <b>EthSamoan</b>                                                    |  |
|                                                                                                                           |  | <input type="checkbox"/> Cook Island Maori <b>EthCookIslandMaori</b>                                |  |
| <input type="checkbox"/> Niuean <b>EthNiuean</b>                                                                          |  | <input type="checkbox"/> Chinese <b>EthChinese</b>                                                  |  |
|                                                                                                                           |  | <input type="checkbox"/> Indian <b>EthIndian</b>                                                    |  |
|                                                                                                                           |  | <input type="checkbox"/> Tongan <b>EthTongan</b>                                                    |  |
| <input type="checkbox"/> Other (such as Dutch, Japanese) <b>EthOther</b>                                                  |  | *(specify) <b>EthSpecify1</b> _____ <b>EthSpecify2</b> _____                                        |  |

| Hepatitis B, C, NOS                                                                                                                                |                                                                            | EpiSurv No. _____                                                                                                                                                    |                                |                                 |                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|----------------------------------------|
| <b>Basis of Diagnosis</b>                                                                                                                          |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| <b>CLINICAL CRITERIA</b>                                                                                                                           |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| Fits Clinical Description* <span style="color: red;">FitClinDes</span>                                                                             |                                                                            | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Unknown   |                                        |
| Clinical features                                                                                                                                  | Jaundice <span style="color: red;">Jaundice</span>                         | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Unknown   |                                        |
| <b>LABORATORY CRITERIA</b>                                                                                                                         |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| Meets laboratory confirmation criteria for disease* <span style="color: red;">LabConf</span>                                                       |                                                                            | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Unknown   |                                        |
| Elevated Serum aminotransferase <span style="color: red;">ElevSerum</span>                                                                         |                                                                            | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
| <b>Hepatitis B</b>                                                                                                                                 | HBsAg positive <span style="color: red;">HBsAg</span>                      | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | Anti-HBc IgM positive <span style="color: red;">AntiHBc</span>             | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | HBV nucleic acid detected <span style="color: red;">HBVPCR</span>          | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
| <b>Hepatitis C</b>                                                                                                                                 | Anti-HCV positive <span style="color: red;">AntiHCV</span>                 | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | HCV nucleic acid detected <span style="color: red;">HCVPCR</span>          | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | Documented seroconversion to HCV <span style="color: red;">Seroconv</span> | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
| <b>Hepatitis NOS</b>                                                                                                                               | Anti-HDV positive <span style="color: red;">AntiHDV</span>                 | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | Anti-HEV positive <span style="color: red;">AntiHEV</span>                 | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | Positive hepatitis G test <span style="color: red;">PosHepG</span>         | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Not Done  | <input type="radio"/> Awaiting Results |
|                                                                                                                                                    | Other positive test (specify) <span style="color: red;">OthPosTest</span>  | _____                                                                                                                                                                |                                |                                 |                                        |
| <b>CLASSIFICATION* <span style="color: red;">Status</span></b>                                                                                     |                                                                            | <input type="radio"/> Under investigation                                                                                                                            | <input type="radio"/> Probable | <input type="radio"/> Confirmed | <input type="radio"/> Not a case       |
| <b>Clinical Course and Outcome</b>                                                                                                                 |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| Date of onset* <span style="color: red;">OnsetDt</span>                                                                                            |                                                                            | <input type="checkbox"/> Approximate <span style="color: red;">OnsetDtApprox</span> <input type="checkbox"/> Unknown <span style="color: red;">OnsetDtUnknown</span> |                                |                                 |                                        |
| Hospitalised* <span style="color: red;">Hosp</span>                                                                                                |                                                                            | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Unknown   |                                        |
| Date hospitalised* <span style="color: red;">HospDt</span>                                                                                         |                                                                            | <input type="checkbox"/> Unknown <span style="color: red;">HospDtUnknown</span>                                                                                      |                                |                                 |                                        |
| Hospital* <span style="color: red;">HospName</span> _____                                                                                          |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| Died* <span style="color: red;">Died</span>                                                                                                        |                                                                            | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Unknown   |                                        |
| Date died* <span style="color: red;">DiedDt</span>                                                                                                 |                                                                            | <input type="checkbox"/> Unknown <span style="color: red;">DiedDtUnknown</span>                                                                                      |                                |                                 |                                        |
| Was this disease the primary cause of death?* <span style="color: red;">DiedPrimary</span>                                                         |                                                                            | <input type="radio"/> Yes                                                                                                                                            | <input type="radio"/> No       | <input type="radio"/> Unknown   |                                        |
| If no, specify the primary cause of death* <span style="color: red;">DiedOther</span> _____                                                        |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| <b>Outbreak Details</b>                                                                                                                            |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*                                        |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |
| <input type="checkbox"/> Yes <span style="color: red;">Outbrk</span> If yes, specify Outbreak No.* <span style="color: red;">OutbrkNo</span> _____ |                                                                            |                                                                                                                                                                      |                                |                                 |                                        |

| <b>Hepatitis B, C, NOS</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                     | EpiSurv No. _____                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <b>Risk Factors</b>                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                     |                                                               |
| Household contact with a confirmed case (or carrier)* <span style="color: red;">HHoldCont</span>                                                                                                                                                                                                 | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| Sexual contact with confirmed case (or carrier)* <span style="color: red;">SexCont</span>                                                                                                                                                                                                        | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| Child of seropositive mother* <span style="color: red;">PosMother</span>                                                                                                                                                                                                                         | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| Occupational exposure to blood (e.g. health care worker)* <span style="color: red;">ExpBlood</span>                                                                                                                                                                                              | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| If yes, specify exposure detail:* <span style="color: red;">ExpBloodSpec</span> _____                                                                                                                                                                                                            |                                                                                                                                                                                                     |                                                               |
| Was the case overseas during the incubation period (Hepatitis B = 45-180 days; Hepatitis C = 2 weeks - 6 months) for this disease?* <span style="color: red;">Overseas</span>                                                                                                                    | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| History of injecting drug use:* <span style="color: red;">IDUHistory</span>                                                                                                                                                                                                                      | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| Has the case undergone body piercing or tattooing procedure(s) in the last 12 months?* <span style="color: red;">BodyPierce</span>                                                                                                                                                               | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| If yes, specify*<br>Date of most recent procedure* <span style="color: red;">DtBodyPierce</span> _____ or <input type="checkbox"/> Unknown <span style="color: red;">DtBodyPierceUnknown</span><br>Premise/place of most recent procedure* <span style="color: red;">PremBodyPierce</span> _____ |                                                                                                                                                                                                     |                                                               |
| Blood product or tissue recipient* <span style="color: red;">BloodRec</span>                                                                                                                                                                                                                     | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| If yes, specify most recent date* <span style="color: red;">BloodDate</span> _____ or <input type="checkbox"/> Unknown <span style="color: red;">BloodDateUnknown</span>                                                                                                                         |                                                                                                                                                                                                     |                                                               |
| Other risk factors for Hepatitis B, C or NOS infection (specify)* <span style="color: red;">RiskOthSpecify</span>                                                                                                                                                                                |                                                                                                                                                                                                     |                                                               |
|                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                     |                                                               |
| <b>Protective Factors (Hepatitis B only)</b>                                                                                                                                                                                                                                                     |                                                                                                                                                                                                     |                                                               |
| At any time prior to onset, had the case been immunised with hepatitis B vaccine?* <span style="color: red;">Immunised</span>                                                                                                                                                                    | <input type="radio"/> Yes                                                                                                                                                                           | <input type="radio"/> No <input type="radio"/> Unknown        |
| If yes, specify vaccine details                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                     |                                                               |
| First administered dose:* <span style="color: red;">FirstDose</span>                                                                                                                                                                                                                             | <input type="radio"/> Hep B                                                                                                                                                                         | <input type="radio"/> Unknown                                 |
| Date given* <span style="color: red;">DtFirstDose</span> _____                                                                                                                                                                                                                                   | Or age when 1st dose given <span style="color: red;">AgeFirstDose</span> ____ <span style="color: red;">YMWFirstDose</span> <input type="radio"/> W <input type="radio"/> M <input type="radio"/> Y |                                                               |
| Source of information:* <span style="color: red;">SceFirstDose</span>                                                                                                                                                                                                                            | <input type="radio"/> Patient/caregiver recall                                                                                                                                                      | <input type="radio"/> Documented                              |
| Second administered dose:* <span style="color: red;">SecndDose</span>                                                                                                                                                                                                                            | <input type="radio"/> Hep B                                                                                                                                                                         | <input type="radio"/> Not given <input type="radio"/> Unknown |
| Date given* <span style="color: red;">DtSecndDose</span> _____                                                                                                                                                                                                                                   | Or age when 2nd dose given <span style="color: red;">AgeSecndDose</span> _ <span style="color: red;">YMWSecndDose</span> <input type="radio"/> W <input type="radio"/> M <input type="radio"/> Y    |                                                               |
| Source of information:* <span style="color: red;">SceSecndDose</span>                                                                                                                                                                                                                            | <input type="radio"/> Patient/caregiver recall                                                                                                                                                      | <input type="radio"/> Documented                              |
| Third administered dose:* <span style="color: red;">ThirdDose</span>                                                                                                                                                                                                                             | <input type="radio"/> Hep B                                                                                                                                                                         | <input type="radio"/> Not given <input type="radio"/> Unknown |
| Date given* <span style="color: red;">DtThirdDose</span> _____                                                                                                                                                                                                                                   | Or age when 3rd dose given <span style="color: red;">AgeThirdDose</span> ____ <span style="color: red;">YMWThirdDose</span> <input type="radio"/> W <input type="radio"/> M <input type="radio"/> Y |                                                               |
| Source of information:* <span style="color: red;">SceThirdDose</span>                                                                                                                                                                                                                            | <input type="radio"/> Patient/caregiver recall                                                                                                                                                      | <input type="radio"/> Documented                              |
| Fourth administered dose:* <span style="color: red;">FourthDose</span>                                                                                                                                                                                                                           | <input type="radio"/> Hep B                                                                                                                                                                         | <input type="radio"/> Not given <input type="radio"/> Unknown |
| Date given* <span style="color: red;">DtFourthDose</span> _____                                                                                                                                                                                                                                  | Or age when 4th dose given <span style="color: red;">AgeFourthDose</span> _ <span style="color: red;">YMWFourthDose</span> <input type="radio"/> W <input type="radio"/> M <input type="radio"/> Y  |                                                               |
| Source of information:* <span style="color: red;">SceFourthDose</span>                                                                                                                                                                                                                           | <input type="radio"/> Patient/caregiver recall                                                                                                                                                      | <input type="radio"/> Documented                              |

| Hepatitis B, C, NOS                                                                                                 |                                                  | EpiSurv No. _____                                                                |
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| <b>Management</b>                                                                                                   |                                                  |                                                                                  |
| <b>CASE MANAGEMENT</b>                                                                                              |                                                  |                                                                                  |
| Case counselled about risk of transmission to others? <span style="color: red;">CaseCounsel</span>                  |                                                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| <b>CONTACT MANAGEMENT</b>                                                                                           |                                                  |                                                                                  |
| Was the case pregnant? <span style="color: red;">CasePregn</span>                                                   |                                                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Did case have any contacts at risk of infection? <span style="color: red;">ContRisk</span>                          |                                                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| If yes, describe contacts and their management                                                                      |                                                  |                                                                                  |
| <b>Type of contact</b>                                                                                              | <b>Number identified</b>                         | <b>Number counselled</b>                                                         |
| Child of carrier mother                                                                                             | <span style="color: red;">NoPMoth</span> _____   | <span style="color: red;">NoPMothCou</span> _____                                |
| Household contacts                                                                                                  | <span style="color: red;">NoHHold</span> _____   | <span style="color: red;">NoHHoldCou</span> _____                                |
| Sexual contacts                                                                                                     | <span style="color: red;">NoSexCont</span> _____ | <span style="color: red;">NoSexCCou</span> _____                                 |
| Percutaneous contacts (e.g. Needlestick Injury, Needle Sharing)                                                     | <span style="color: red;">NoPerc</span> _____    | <span style="color: red;">NoPercCou</span> _____                                 |
| Other contacts (specify) <span style="color: red;">ContOtherSpec</span>                                             | <span style="color: red;">NoOthr</span> _____    | <span style="color: red;">NoOthrCou</span> _____                                 |
|                                                                                                                     |                                                  | <b>Number advised to get vaccine (hep B only)</b>                                |
|                                                                                                                     |                                                  | <span style="color: red;">NoPMothVac</span> _____                                |
|                                                                                                                     |                                                  | <span style="color: red;">NoHHoldVac</span> _____                                |
|                                                                                                                     |                                                  | <span style="color: red;">NoSexCVac</span> _____                                 |
|                                                                                                                     |                                                  | <span style="color: red;">NoPercVac</span> _____                                 |
|                                                                                                                     |                                                  | <span style="color: red;">NoOthrVac</span> _____                                 |
|                                                                                                                     |                                                  | <b>Number given IG (hep B only)</b>                                              |
|                                                                                                                     |                                                  | <span style="color: red;">NoPMothIG</span> _____                                 |
|                                                                                                                     |                                                  | <span style="color: red;">NoHHoldIG</span> _____                                 |
|                                                                                                                     |                                                  | <span style="color: red;">NoSexCIG</span> _____                                  |
|                                                                                                                     |                                                  | <span style="color: red;">NoPercIG</span> _____                                  |
|                                                                                                                     |                                                  | <span style="color: red;">NoOthrIG</span> _____                                  |
| <b>Comments*</b>                                                                                                    |                                                  |                                                                                  |
| <div style="color: red;">Comments</div> <div style="border: 1px solid #ccc; height: 300px; margin-top: 5px;"></div> |                                                  |                                                                                  |