

Manitoba Health and Healthy Living Investigation Form for Hepatitis B and C Positive Cases



Category of Disease (check all that apply):

- Hepatitis B Acute Chronic (or Chronic Carrier) Status Unspecified
- Hepatitis C (does not distinguish acute from chronic)

Specimen Collection Date (YYYY/MM/DD) _____

Surname _____ Given Name _____

PHIN _____ Sex M F Other or unknown _____

MH Registration Number _____ Birth Date (YYYY/MM/DD) _____

Street Address _____ City/Town _____ Province _____ Postal Code _____

Alternate Address Information _____ Telephone (home/work/cell) _____

Past History (complete when applicable)

Previously tested positive for: HBV HCV Unspecified Hepatitis

Date of first positive hepatitis B test (YYYY/MM/DD) _____

Date of first positive hepatitis C test (YYYY/MM/DD) _____

Where tested positive (province/country) _____

Previous blood/tissue donation: Yes No

If Yes, most recent date (YYYY/MM/DD) _____

Hospital or facility: _____

Immunization History:

Previous hepatitis B immunization Yes No Unknown

If yes, dates of each dose: 1: _____ (YYYY/MM/DD)

2: _____ (YYYY/MM/DD)

3: _____ (YYYY/MM/DD)

If HBV immunization received, has protective antibody response been documented? Yes: _____ (YYYY/MM/DD) No Unknown

Client is aware that if there is a history of blood transfusion, Manitoba Health and Healthy Living is required to notify Canadian Blood Services

History of Present Illness (check all that apply)

Symptoms present: Yes No Unknown Onset date of symptoms: _____ (YYYY/MM/DD)

To record specific symptoms, see reverse or list: _____

Has the client been informed of this hepatitis antibody test result? Yes No Unknown

If HCV positive and susceptible to HBV, has HBV vaccine been offered? Yes No Unknown

If HCV or HBV-positive, has HAV vaccine been offered? Yes No Unknown

If client is HBV-positive and pregnant, have plans been made for newborn prophylaxis with HBV immune globulin and HBV vaccine?
 Yes No Unknown

Client is aware, that unless stated otherwise, public health follow-up will occur? Yes Refuses public health follow-up

Self-identified Ethnicity (check one)

- Caucasian
- Black (i.e., African, Haitian, Jamaican, etc.)
- Asian (i.e., Chinese, Filipino, Japanese, etc.)
- South Asian (i.e., East Indian, Pakistani, Sri Lankan, etc.)
- Arab/West Asian (i.e., Armenian, Egyptian, Iranian, etc.)
- Latin American
- Aboriginal (specify)
 - First Nation on Reserve
 - First Nation off Reserve
 - Métis
 - Inuit
 - Other (specify) _____
 - Refused to answer

Country of Birth (check one)

Canada Other (specify) _____ Year of arrival in Canada (YYYY) _____

Risk Factors for Disease Acquisition and Transmission (check all that apply)

- History of residence in an endemic country. Country: _____
- Child of hepatitis-positive mother
- History of incarceration

Sexual Exposure

	For Hep B (in past 6 mo.)		For Hep C (in past 12 mo.)		For both Hep B & C		
	Ever	Never	Ever	Never	Unknown		
Sexual contact with confirmed or suspect case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Multiple sex partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sex trade worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Men having sex with men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sexual assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Injection drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Household contact with confirmed or suspect case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood/blood product recipient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ (YYYY/MM/DD)	
Hemodialysis/peritoneal dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Onset year: _____ (YYYY)	
Major surgery/clinical exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ (YYYY/MM/DD)	
Tattoos/ear & other piercings/acupuncture/scarification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ (YYYY/MM/DD)	
Needlestick/occupational exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ (YYYY/MM/DD)	
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ (YYYY/MM/DD)	

No identifiable risk factor

- Ever

Disease Reporting Information (check all that apply)

As per Manitoba Health and Healthy Living protocol, individuals with Hepatitis B or C should be tested for associated bloodborne pathogens:

Type	Parallel BBP Tests Performed on Case	
HBV	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> N/A	▶ if positive, report to surveillance system and refer for treatment
HCV	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> N/A	▶ if positive, report to surveillance system and refer for treatment
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> N/A	▶ if positive, report to surveillance system and refer for treatment

Form completed by (print practitioner's name) _____ Telephone Number _____

Signature _____ Form completion date (YYYY/MM/DD) _____

If public health follow-up required:

Form completed by (print public health staff name) _____ Telephone Number _____

Signature _____ Form completion date (YYYY/MM/DD) _____

**Manitoba Health and Healthy Living Investigation Form for Hepatitis B and C Positive Cases
Instructions and Public Health Notes**

Category of Disease (Acute, Chronic or Unspecified) As per Manitoba Health and Healthy Living provincial case management protocols for HBV and HCV

Address Please ensure that client's primary permanent address is completed; if it differs from that provided on the lab report, provincial records will be updated.

Past History This section is important for the identification of repeat testers, interprovincial follow-up (if tested previously in another province), and possible identification of newly acquired infection. A new case of hepatitis infection is defined by using the positive test result related to an individual's name (with other personal identifiers) that has not been previously associated with a positive hepatitis B or C diagnosis in Manitoba.

History of Present Illness Please note that specific symptoms for case management are listed on the reverse of the form for case management.

Ethnicity Clients should self-identify their ethnicity (and they have the right to refuse to answer). Aboriginal-specific categories have been requested by a number of Aboriginal communities and service providers.

Risk Factors This information is valuable epidemiologic information used to inform program and policy development. Please encourage accurate reporting by clients. For the dates requested in this section, please list the date of last exposure. Major surgery and clinical exposures include dental surgery and percutaneous clinical needle exposure.

Informing Questions related to the information provided to clients re: legal obligations and referral to specialist, will be used to assess adherence to provincial protocol. If not completed, public health staff may contact the practitioner reporting this case as follow-up.

Manitoba Health and Healthy Living Follow-up If the client reports a sexual assault, an occupational exposure, a blood/blood product exposure, or blood/tissue donation, public health staff may contact the person who completed the form for clarification.

Region-specific Questions for Case Management (or "Additional Questions for Case Management")

Additional locating information: _____

Symptoms:

Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Dark urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Pale stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Right upper quadrant discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Other: _____			

Treatment information:
If HBV-positive, referred for treatment?: Yes No Unknown Date: _____(YYYY/MM/DD)
If HCV-positive, referred for treatment?: Yes No Unknown Date: _____(YYYY/MM/DD)

Other treatment information: _____

Provider information: _____

Other client information: _____

Contact information: _____

Signature: _____

ONLY THE FIRST PAGE (the surveillance information) should be faxed to Manitoba Health and Healthy Living:

Fax to Manitoba Health and Healthy Living:
Public Health Disease Surveillance System
Public Health Division, Manitoba Health and Healthy Living
4th floor – 300 Carlton Street
Winnipeg, Manitoba R3B 3M9
CONFIDENTIAL FAX: 204-948-3044