# Hepatitis B

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

Lillian Rivera, RN, MSN, PhD, Administrator

## HEPATITIS B REPORT FORM (*Page 1*)

**Please complete this form and fax back to (305) 470-5533 by 4:00 PM today. It is very important to include in your returned fax with the results of the patient's hepatitis panel including IgM anti- HBc results and liver enzyme levels.**

Part I: Demographics

**Date:** ____________________

**Patient name:** ____________________ (Last) (First) (M.I.)

**Occupation:** ____________________

**Birthdate:** ____________________

**Phone:** ____________________ (home)

____________________ (work)

**Address:** ____________________ (Street / Apt. #)

____________________ (City) (State) ( Zip Code)

**Sex:** ____ Male
____ Female

**Race:** ____ American Indian/Alaskan Native
____ Asian or Pacific Islander
____ Black
____ White

**Ethnicity:** ____ Hispanic
____ Non-Hispanic

**If patient is a male disregard next page**

Part II: Clinical Information

Was patient hospitalized for hepatitis? [Yes] [No] [Unk]

If yes, name of hospital: ____________________
Admitted: ____________ Discharged: ____________

Was this patient a contact to a confirmed case of Hepatitis B? .............................................. [Yes] [No] [Unk]

Were the patient's household and sexual contacts tested for hepatitis B? ............................. [Yes] [No] [Unk]

Was this patient diagnosed with acute or chronic hepatitis B? ......................... ....... ____Acute ___Chronic

**Date of diagnosis:** ____/____/____

Did the patient have symptoms? ....................... [Yes] [No] [Unk]

If yes,

**Date of onset:** ____/____/____

First symptom: ................................. ____________________

Please Mark Symptoms:

| Symptom: | Yes | No | Unk | Symptom: | Yes | No | Unk | Symptom: | Yes | No | Unk |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jaundice | | | | Dark Urine | | | | Abd. pain | | | |
| Nausea | | | | Light stools | | | | Fatigue | | | |
| Vomiting | | | | Fever | | | | Other | | | |

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## HEPATITIS B REPORT FORM (*Page 2*)

### Perinatal Hepatitis B Screening

**Is patient currently pregnant or has been pregnant in the past 12 months?**

**Yes ☐ How many weeks?** ____________ **Estimated Date of delivery** ____________

**No ☐** **Postpartum ☐** **Unknown ☐**

Part III: Delivery Hospital Information Request

**If Yes or Postpartum, please complete Part III**

Child's Name: ____________ **D.O.B:** ____________

Child's Pediatrician: ____________ Time of Birth: ____________

Child's Address: ____________ Hospital: ____________

____________

(City) (State) (Zip Code)

**Mother Information:**

Name: ____________ **D.O.B:** ____________

Address: ____________ Telephone: ____________

____________ Other Telephone: ____________

**Father's Information:**

Name: ____________ **D.O.B:** ____________

Address: ____________ Telephone: ____________

____________ Other Telephone: ____________

**Name of person completing form:** Phone number:

____________ ____________

**HBIG:** Given ☐ Not Given ☐

Date: ____________ Time: ____________ Manufacturer: ____________ Dosage: ____________

Brand Name: ____________ Lot #: ____________

**Hepatitis B Vaccine:** Given ☐ Not Given ☐

Date: ____________ Time: ____________ Manufacturer: ____________ Dosage: ____________

Brand Name: ____________ Lot #: ____________

**Comments:** ____________

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