PublicHealth
WELLINGTON-DUFFERIN-GUELPH
*Stay Well.*

# Viral Hepatitis B (HBV) Investigation Questionnaire for Healthcare Providers

## Demographic Information

| | |
|---|---|
| **Client name (last, first):** | **DOB *(yyyy/mm/dd)*:** |
| **Home phone:** | **Cell phone:** |
| **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Other, please specify: | |
| **Primary HCP:** | **Primary HCP phone:** |

**Address:** _____

**Address type:** ☐ Private residence
☐ Healthcare facility (hospital, LTCH, RH, addiction/treatment centre)
☐ Other congregate setting (group home, shelter, correctional facility)
☐ Other (please specify, or alternate address):

**Healthcare facility or other congregate setting contact person and phone number (*if applicable*):**

| | | |
|---|---|---|
| **Country of birth:** | **Country of last residence:** | **Arrival date in Canada:** |
| **Primary language:** | **Interpreter required:** ☐ Yes ☐ No | |
| **Client has proxy:** ☐ Yes ☐ No | **Proxy name, relationship, and contact information (*if applicable*):** | |

## Diagnostic Information

**Most recent specimen result:**

| | | |
|---|---|---|
| ☐ HBsAg reactive | ☐ HBsAg non-reactive | ☐ Inconclusive |
| ☐ Anti-HBc (Total) reactive | ☐ Anti-HBc (Total) non-reactive | |
| ☐ Anti-HBc IgM reactive | ☐ Anti-HBc IgM non-reactive | |
| ☐ HBeAg reactive | ☐ HBeAg non-reactive | |
| ☐ Anti-HBe reactive | ☐ Anti-HBe non-reactive | |

**Reason for testing (check all that apply):**

| | |
|---|---|
| ☐ Diagnostic | ☐ Immigration screening |
| ☐ Immune status | ☐ Symptoms/elevated LFT's (see below) |
| ☐ Chronic condition | ☐ Maternal exposure |
| ☐ Prenatal | ☐ Insurance medical screening |
| ☐ Post-exposure (e.g. Needlestick, Close contact) | ☐ Other (please specify) _____ |

| **Client aware of most recent result:** ☐ Yes ☐ No | **Previous test date(s) and locations (*if applicable*):** |
|---|---|

**Symptom onset date (*if applicable*):**

**Symptoms:**

| | | |
|---|---|---|
| ☐ Abdominal pain | ☐ Jaundice | ☐ Loss of appetite/weight |
| ☐ Nausea/vomiting | ☐ Pale stool | ☐ Arthralgia/joint pain |
| ☐ Dark urine | ☐ Malaise/fatigue | ☐ Fever |
| ☐ Other (please specify) _____ | | |

| **Hospitalized:** ☐ Yes ☐ No | **Location and date of admission (*if applicable*):** |
|---|---|

| **Date of death (*if applicable*):** | **Cause of death (*if applicable*):** |
|---|---|

## Ongoing Care

| **Referral to specialist:** ☐ Yes ☐ No | **Treating provider/specialist name or centre:** |
|---|---|

| **Treating provider/specialist phone:** | **Appointment date:** |
|---|---|

**If no referral made, please indicate reason:**

| **Hepatitis A vaccination:** ☐ Yes ☐ No ☐ In progress | **Immunity to Hepatitis A:** ☐ Yes ☐ No | **Date(s) of immunization or immunity testing (*if applicable*):** |
|---|---|---|

**Other vaccinations**: ☐ Pneumococcal 23 (date: _____)
☐ Flu shot (date: _____)

## Risk Factor Information

**Medical risk factors:**

- ☐ Born in an endemic country (location: _____)
- ☐ Born to an HBV case
- ☐ Organ/tissue transplant (date and location: _____)
- ☐ Dialysis recipient (location: _____)
- ☐ Invasive medical/surgical procedure (date and location: _____)
- ☐ Pregnant (EDD: _____)
- ☐ Received blood/blood products (date and location: _____)
- ☐ STI co-infected (please specify: _____)
- ☐ Invasive dental procedures (date and location: _____)
- ☐ Partially immunized or unimmunized against HBV (vaccination dates: _____)
- ☐ Unknown
- ☐ Other (please specify: _____)

**Behavioural/social risk factors:**

| | | |
|---|---|---|
| ☐ High risk sexual activity | ☐ Contact is HBV positive | ☐ Contact is HIV positive |
| ☐ Injection drug use | ☐ Inhalation drug use | ☐ Intranasal drug use |
| ☐ Shared drug equipment | ☐ Shared personal items (e.g., toothbrush, razor blades, sex toys) | |
| ☐ Sex worker | ☐ Acupuncture | ☐ Electrolysis |
| ☐ Homeless/underhoused | ☐ Correctional facility | ☐ Tattoo |
| ☐ Piercing | ☐ Other personal services | ☐ Fighting, biting, blood brother |
| ☐ Healthcare worker | ☐ Occupational exposure to potentially contaminated body fluids | |
| ☐ Recent travel outside of Canada (please specify: _____) | | |
| ☐ Unknown | ☐ Other (please specify: _____) | |

**Additional risk factor details provided by the client:**

## Health Teaching

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|---|---|
| **Health teaching provided:** ☐ Yes (see below) ☐ No | **If no, please indicate reason:** |

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|---|---|
| ☐ Healthy lifestyle and healthy living with HBV | ☐ Harm reduction |
| ☐ Importance of regular HBV monitoring | ☐ Transmission prevention (see below) |
| ☐ Treatment available | ☐ Access/barriers to follow-up care |
| ☐ If pregnant, HBV immunoglobulin administration, HBV vaccination, and serology after birth | |
| ☐ Other vaccinations | ☐ Other (please specify: _____) |

**DO** cover open wounds, clean up blood with freshly prepared bleach solution (1 part bleach: 9 parts water), and dispose of blood contaminated items (e.g., feminine hygiene products, bandages, cloths) in a plastic bag; safely dispose of sharps; disclose HBV status to HCPs (and current/future sexual partners); and practice safer sex (e.g.., condoms, dental dams etc.).

**DO NOT** donate blood, tissue, semen, or human milk; share drug paraphernalia; or share personal hygiene items (e.g., nail clippers/scissors/files, dental floss, toothbrush, razors, and glucometers).

## Contact Investigation

| | |
|---|---|
| **Contacts discussed with client:** ☐ Yes ☐ No<br><br>**Client agrees that they will notify contacts:**<br>☐ Yes ☐ No | **If client does not agree to notify contacts, contact notification to occur by:** ☐ provider ☐ WDGPH<br><br>If WDGPH to complete contact notification, provide the following information regarding contact(s). |

| **Contact name:** | **DOB (*yyyy/mm/dd*):** | **Phone and address:** | **Contact type:** |
|---|---|---|---|
| | | | ☐ Household ☐ Sexual<br>☐ Shared drug equipment<br>☐ Blood exposure<br>☐ Other: |

| | | | |
|---|---|---|---|
| | | | ☐ Household ☐ Sexual<br>☐ Shared drug equipment<br>☐ Blood exposure<br>☐ Other: |
| | | | ☐ Household ☐ Sexual<br>☐ Shared drug equipment<br>☐ Blood exposure<br>☐ Other: |
| | | | ☐ Household ☐ Sexual<br>☐ Shared drug equipment<br>☐ Blood exposure<br>☐ Other: |

| **Additional Comments** |
|---|
| |

| **Signature of provider completing questionnaire:** | **Date:** |
|---|---|
| **Client aware WDGPH may follow up**:<br>☐ Yes ☐ No | **Please fax completed questionnaire to 1-855-934-5463.** |

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