

HEPATITIS B AND C - CASE INVESTIGATION

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

A positive: **Hepatitis B** or **Hepatitis C** report has been received from the Public Health Laboratory on your patient.

Name:	HCP#
Date of Birth: Y: _____ M: _____ D: _____ or Age: _____	
Address:	

Please provide the following information on this patient		
Reason for Testing:		
Acute Hepatitis <input type="checkbox"/>	High Risk Exposure <input type="checkbox"/>	Sexual Exposure <input type="checkbox"/>
Chronic Symptoms <input type="checkbox"/>	Illicit Drug Use <input type="checkbox"/>	Maternal <input type="checkbox"/>
Have contacts been followed (see page #2 for list of contacts): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has this person donated blood <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, <u>where and when</u> was last donation? Where: _____ When: _____		

POSSIBLE RISK BEHAVIOUR	YES	NO	COMMENTS
Men who have sex with men			
Heterosexual sex with injection drug user			
Heterosexual sex with confirmed or suspected hepatitis case			
Injected non-prescription drugs (at any time in the past including steroids)			
Received pooled concentrates for treatment of haemophilia or coagulation disorder*			
Received transfusion of whole blood or blood components*			
Occupational exposure to hepatitis contaminated blood or body fluids or concentrated virus			
Perinatal transmission			
Contact with a person who lived in an area where these diseases are prevalent			
Household contact with confirmed or suspected case of hepatitis			
Body piercing or tattoo			
Acupuncture, dialysis, EEG, dental, other (specify)			
*If <u>yes</u> to these questions, please note the institution where this was given and the year:			
Present treatment: (type, list drugs, date)			
Hospitalized: <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Hospital: _____			

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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				
Symptomatic Yes <input type="checkbox"/> No <input type="checkbox"/> Specify:				
Treated Specify:				

Comments:

Person Reporting:

Title:

Place:

Date:

Signature:

Please return this completed form to:

**Office of the Chief Medical 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**