Health Care Provider (HCP) Hepatitis B Virus (HBV) Surveillance Form

Please complete sections A, B, and C below to report necessary information to the Medical Officer of Health at Toronto Public Health (as required under the *Health Protection and Promotion Act, RSO 1990 c.H.7)* as soon as you receive a positive HBV result and/or make a clinical diagnosis. This fillable PDF form can be completed digitally or in print and be emailed to cdcBloodborne@toronto.ca. Blank copies of this form are available on our website: Toronto.ca/hepatitis.

Patient Information

First Name: _____

Last Name: _____

DOB: _____

Age: _____

iPHIS # (TPH Staff Only): _____

HCP INFORMATION

Name: _____

Signature: _____

Date: _____

CDI Information

Name: _____

Email: CDCBloodborne@toronto.ca

Phone: 416-338-8400
(leave a voicemail on our intake line)

Work Hours: 0830-1630hrs, Mon-Fri

SECTION A: Testing

1. Which is your impression of the HBV Diagnosis (case classification)?

- ☐ Patient has symptoms and/or has HBV IgM (acute HBV infection)
- ☐ HBsAg+ greater than 6 months (chronic HBV infection)
- ☐ First HBsAg+ result identified in Ontario, but possible chronic infection based on history (undetermined)

2. Reason(s) for HBV surface antigen (HBsAg) testing (please check all that apply):

- ☐ Increased risk identified
  (please select the risk(s) identified in question 3)
- ☐ Routine Screening (inc. employment screening or screening for those with continued exposure)
- ☐ Prenatal, EDD:
  _____ (DD/MM/YYYY)
- ☐ Pre-immunosuppression assessment
- ☐ Post-vaccination serology (PVS), last dose:
  _____ (DD/MM/YYYY)
- ☐ Presented with symptoms
- ☐ Presented with evidence of liver disease
  (e.g., elevated ALT, physical exam)
- ☐ Other, please specify:
  _____
  _____
  _____
  _____

Information collected on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c.H.7, Ontario Regulation 569/90 - Reports, and Ontario Regulation 559/91 - Specification of Reportable Diseases. It is used to investigate cases of hepatitis B infection, for patient care, to manage potential risks to others or to the population at large, and for resource planning and quality assurance. Questions regarding this collection should be directed to Toronto Public Health's Bloodborne Disease-Infection Prevention and Control Program by phone at 416-338-7600.

3. Risk Factors (please check all that apply):

- ☐ Hepatitis C or HIV infection
- ☐ Current or past drug use or client at an Opioid Agonist Therapy clinic
- ☐ Incarceration
- ☐ Born or ☐ lived in an endemic country (please specify country and year came to Canada: _____)
- ☐ Patient born to a birthing parent with HBV infection
- ☐ Household or caregiver with HBV infection
- ☐ Sexual/intimate partner contact with HBV infection
- ☐ Occupational exposure (e.g. healthcare worker)
- ☐ Suspected exposure in aesthetic/body modification, medical, dental, or other setting within the last two years.
  Please specify type and location of exposure setting:
  - ☐ Type: _____ ☐ Location of setting: _____ (City, Country)
- ☐ Immunosuppressed, please specify: _____
- ☐ Other, please specify: _____

4. Was the patient aware of their HBV status prior to this diagnosis?

☐ Yes ☐ No ☐ Did not ask ☐ Unknown

5. Does the patient report having ever received an HBV vaccine?

☐ Yes, approximately when was each dose given, if known:

- ☐ _____ (DD/MM/YYYY)
- ☐ _____ (DD/MM/YYYY)
- ☐ _____ (DD/MM/YYYY)
- ☐ _____ (DD/MM/YYYY)
- ☐ _____ (DD/MM/YYYY)
- ☐ _____ (DD/MM/YYYY)
- ☐ _____ (DD/MM/YYYY)

☐ No ☐ Did not ask ☐ Unknown

6. Is the patient deceased?

☐ No

☐ Yes, Date of death: _____ (DD/MM/YYYY);

Cause of death, if known: _____

☐ Yes, Patient deceased, details unknown

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SECTION B: Counselling and Clinical Follow Up

Please confirm completion of all steps by checking the boxes below or indicate if the patient has been lost to follow up:

☐ **Patient has been lost to follow up**

Clinician's Next Step	Completed	Planning to do	Will not complete	Provide more information
Notified patient of test results and provided counselling on preventing transmission and educating contacts (TPH **HBV quick reference guide**; CATIE **HBV resources**; TPH **Hepatitis Information for Health Professionals**) (see section C: Contact Follow Up for Contacts of HBV Cases).	☐	☐	☐	
Ordered HBV DNA testing (if not already completed).	☐	☐	☐	
Referred or conducted assessment for HBV care/treatment.	☐	☐	☐	Name of treating provider: _____
Ordered FREE HAV vaccines for patient using **TPH's Vaccine Order Form**	☐	☐	☐	☐ Patient received complete HAV vaccine series.

Reminder

Order liver and renal tests, and test for the following infectious disease markers, to assess treatment or prior to referral to care/treatment:

- Quantitative HBsAg and HBV DNA
- HBeAg and HBeAb
- Anti-HCV (HCVAb)
- Hepatitis delta Ab (HDV)
- HAV immune status (HAV IgG)
- HIV
- CBC
- ALT
- AST
- Bili
- Albumin
- Creatinine
- Abdominal ultrasonography and AFP for patients with/who are:
  - Men aged >40 years, women aged >50 years
  - African ancestry aged ≥ 30 years
  - Aged 40 years and first-degree relative with HCC or 10 years before family diagnosis
  - Both HBV and HIV or HBV and HDV

Note: Testing from Public Health Ontario Laboratory **(requisition)** are covered for anyone in Ontario, including uninsured patients **(Test Information Index)**.

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SECTION C: Contact Follow Up for Contacts of HBV Cases

1. Does the patient have identifiable contacts?

☐ Yes, total number: _____

- ☐ Drug use contacts
- ☐ Household contacts
- ☐ Sexual contacts:
  - ☐ Unprotected ☐ Protected
- ☐ Pediatric contacts or infants < 12 months old born to patient with chronic HBV

☐ No

Please ensure the completion of the following steps for contacts:

Clinician's Next Step	Completed	Planning to do	Will not complete	Provide more information
Verified patient will follow up with their contacts	☐	☐	☐	
Offered adult contacts: • Testing for HBV immune status (anti-HBs) and chronic infection (HBsAg and total anti-HBc)	☐	☐	☐	Immunization date(s): _____ (DD/MM/YYYY)
• Complete vaccine series if non-immune and negative **(TPH Vaccine Order Form)**	☐	☐	☐	_____ (DD/MM/YYYY)
• Complete **Post-Vaccination Serology**	☐	☐	☐	_____ (DD/MM/YYYY)
Ordered for infants <12 mo. born to parents with chronic HBV, or any pediatric contacts: • Complete HBV vaccine series **(TPH Vaccine Order Form)**	☐	☐	☐	Immunization date(s): _____ (DD/MM/YYYY) _____ (DD/MM/YYYY)
• Complete **Post-Vaccination Serology**	☐	☐	☐	_____ (DD/MM/YYYY)

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