



Case definitions	
<b>Acute hepatitis B</b>	HBsAg positive and anti-HBc IgM positive with abnormal liver function tests consistent with acute viral hepatitis or:
<b>Chronic hepatitis B</b>	HBsAg positive 6 months apart Or HBsAg positive and anti-HBc IgM negative and anti-HBc positive

## Hepatitis B Epidemiology surveillance Form: Report of newly identified individual with **hepatitis B**

Patient details (please complete fields in CAPITALS)			
Surname		Forename	
Lab no:		Soundex/ Initials	
DOB:		Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known

Laboratory details:	
Source lab	Date of first specimen (dd/mm/yyyy):
Results	HBsAg: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Anti-HBc IgM: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done (If <b>positive</b> , please indicate level: <input type="checkbox"/> <200iu <input type="checkbox"/> ≥200iu)
<b>Type of case:</b>	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Not sure <input type="checkbox"/> Not known

Acute cases only - Please tick probable route of acquisition and give details:		
Route	Tick	Details
Sex between men	<input type="checkbox"/>	
Sex between men and women	<input type="checkbox"/>	
Sex under the influence of recreational drugs	<input type="checkbox"/>	
Injecting drug use	<input type="checkbox"/>	
Performance enhancing drugs (inc. steroids)	<input type="checkbox"/>	
Blood transfusion	<input type="checkbox"/>	
Blood products	<input type="checkbox"/>	
Surgical/ dental treatment	<input type="checkbox"/>	
Occupational (including HCW)	<input type="checkbox"/>	
Tattoo/body piercing	<input type="checkbox"/>	
Mother to child	<input type="checkbox"/>	
Family/ household	<input type="checkbox"/>	
Other (please specify)	<input type="checkbox"/>	
No information	<input type="checkbox"/>	

Was the infection acquired abroad?  Yes  No  Not known If **yes**, which country: .....

Chronic infections only – reason for test (please tick)
<input type="checkbox"/> Blood donor <input type="checkbox"/> Health care worker <input type="checkbox"/> Antenatal <input type="checkbox"/> Liver disease <input type="checkbox"/> Other/ NK .....

Completed by (PRINT NAME):	Date (dd/mm/yyyy):
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Please upload and attach to relevant HPzone case