Viral Hepatitis Investigation Form
(Hepatitis B and Hepatitis C)

Manitoba Health
Communicable Disease Control
300 - 800 Portage Ave.
Winnipeg, Manitoba
R3G 0N4
(204) 945-5436

SURNAME | GIVEN NAME | DATE OF BIRTH (YEAR / MO. / DAY)

ADDRESS | SEX ☐ Male ☐ Female

POSTAL CODE | HOME TELEPHONE NO. | MH # | P.H.I.N.

OCCUPATION | WORK TELEPHONE NO.

ALIAS SURNAME | GIVEN NAME | SPOUSE SURNAME | GIVEN NAME

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Separated Divorced ☐ Common-Law

If female, pregnant? ☐ Yes ☐ No
Expected date of delivery: YEAR / MO. / DAY

COUNTRY OF BIRTH | If not Canada, year of arrival in Canada

ETHNICITY ☐ Caucasian ☐ Aboriginal ☐ Asian ☐ Afro-American ☐ Other (Specify)

If Aboriginal, indicate Treaty status ☐ Treaty ☐ Non-Treaty | BAND NO.

ATTENDING PHYSICIAN | Contacted? YES ☐ NO ☐ | DATE

ADDRESS | TELEPHONE NO.

Reason for testing
(Please give principal reason only)

LABORATORY RESULTS (All dates should be shown as YYYY / MM / DD unless otherwise indicated)

	POS.	NEG.	NOT DONE	Date (YEAR / MO. / DAY)
HBs Ag	☐	☐	☐	
Anti-HBs	☐	☐	☐	
HBe Ag	☐	☐	☐	
Anti-HBe	☐	☐	☐	
Anti-HBc	☐	☐	☐	
Anti-HBc IgM	☐	☐	☐	
Anti-HCV	☐	☐	☐	

If Anti-HCV positive, date of first ever HCV positive result: ☐ Same ☐ Previous (YEAR / MO.)

	POS.	NEG.	NOT DONE
HCV-RNA	☐	☐	☐
Anti-HAV	☐	☐	☐
Anti-HAV IgM	☐	☐	☐
Other	☐	☐	Specify: _____ (YEAR / MO. / DAY)

HISTORY OF PRESENT ILLNESS

Symptoms present: ☐ Yes ☐ No — If present, date of onset of symptoms: (YEAR / MO. / DAY)

- Anorexia ☐
- Nausea / Vomiting ☐
- Fever ☐
- Jaundice ☐
- Rash ☐
- Dark Urine ☐
- Pale Stools ☐
- Fatigue ☐
- Right Upper Quadrant Discomfort ☐
- Other (Specify) _____

Liver aminotransferase levels >2.5 times upper limit of normal (YEAR / MO. / DAY)
☐ Yes ☐ No ☐ Not Done

OTHER HISTORY

History of blood donation? ☐ Yes ☐ No (YEAR / MO.)

Ever received HBV immunization? ☐ Yes ☐ No

#1 | #2 | #3

If HBV immunization received, has antibody response been documented? (YEAR / MO. / DAY)
☐ Yes ☐ No

PRESUMPTIVE DIAGNOSIS

☐ Hepatitis B	☐ Acute	☐ Chronic / Chronic carrier	☐ Cannot tell whether acute or chronic
☐ Hepatitus C	☐ Acute	☐ Chronic	☐ Cannot tell whether acute or chronic

RISK ASSESSMENT (may be more than one risk factor)

History of residence in an endemic country . . . . . ☐ Country _____
Hemophilia / other hematological disorder requiring transfusion . . . . . ☐
Infant or child of a mother with hepatitis . . . . . ☐
History of incarceration . . . . . ☐

Sexual Exposure	In past 6 months	Ever	
Sexual contact with confirmed or suspected case	☐	☐	
Multiple sex partners	☐	☐	
Sex trade worker	☐	☐	
Men having sex with men	☐	☐	
IV drug use	☐	☐	
Household contact with confirmed or suspected case	☐	☐	
Recipient of blood / blood product	☐	☐	Institution and year: _____
Hemodialysis / peritoneal dialysis	☐	☐	Institution and year: _____
Major surgery (including dental surgery)	☐	☐	Location and year: _____
Tattoos, ear / body piercing, acupuncture, scarification	☐	☐	Source and year: _____
Needlestick / occupational exposure	☐	☐	Source and year: _____
Other	☐	☐	Specify: _____
No identifiable risk factor		☐	

EDUCATION

Repeat HBV tests to determine	**Transmission**	**Preventive measures**	**Health promotion**
☐ Carrier status	☐ Sexual contacts	☐ Blood & body fluid precaution	☐ Diet
☐ Immunity	☐ Household contacts	☐ Household contacts	☐ Exercise
☐ Incubation period	☐ Injection drug use	☐ Sexual contacts	☐ Alcohol / Drugs
☐ Asymptomatic vs symptomatic	☐ Infants / Breastfeeding	☐ Needle sharing contacts	
☐ Possible complications	☐ Dental / Medical Care	☐ Risk reduction	
☐ Treatment regimen	☐ Occupational		

FOLLOW-UP

	YES	NO	
1. If HCV positive and susceptible to HBV, has HBV vaccine been offered?	☐	☐	
2. If HCV or HBV positive, has HAV vaccine been offered?	☐	☐	
3. Is the likely source of infection receipt of blood or blood products?	☐	☐	
(If yes, or if there is a history of blood donation, Manitoba Health to inform Canadian Blood Services)			
4. If patient is HBV positive and pregnant, have plans been made for prophylaxis of the newborn with HBV Immune Globulin and HBV vaccination?	☐	☐	
5. Contacts: Has the case been interviewed for contacts?	☐	☐	☐ REFUSED

CASE DISPOSITION

☐ Managed by attending physician alone
☐ Managed by attending physician alone, with PHN interview and education
☐ Referred to VHIU / hepatologist for management (± follow-up by attending physician)
☐ Referred to VHIU / hepatologist for management with prior PHN interview and education
☐ Referred elsewhere (Specify) _____
☐ Other (Specify) _____

Signature _____ Date YEAR ____ / MONTH ____ / DAY ____