VIRAL HEPATITIS B CARE FORM

As cited in the Department Memorandum No. 2019-0062, physicians and health care providers of the demonstration project facilites shall provide and report data to the Epidemiology Bureau, Department of Health.

Please write in CAPITAL LETTERS and CHECK the appropriate boxes.

I. VISIT INFORMATION *(If Case Report Form was accomplished, please proceed to Clinical Assessment section.)*

Consult date: *(mm/dd/yyyy)* ____ / ____ / _____ **Patient code:** ☐☐☐ - H B - ☐☐☐☐ - ☐☐☐ - ☐☐☐

Facility name: **Unique Identifier Code [UIC]:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Facility address: **Client contact #:**

Facility contact info: **Client type:** ☐ Walk-in ☐ Referral ☐ In-patient ☐ Others

II. DEMOGRAPHIC DATA

Patient's full name: **Philhealth #:**

Birthdate: *(mm/dd/yyyy)* ____ / ____ / _____ **Height:** *(in cm.)*

Age in years: **Weight:** *(in kg.)*

Sex at birth: ☐ Male ☐ Female If female, is she currently **pregnant?** ☐ Yes ☐ No

III. CLINICAL ASSESSEMENT

Signs and symptoms	Result		Laboratory tests	Date Done	Result	
Jaundice	☐ Yes	☐ No	HBsAg	/ /	☐ Positive	☐ Negative
Ascites	☐ Yes	☐ No	HBeAg	/ /	☐ Positive	☐ Negative
Fatigue	☐ Yes	☐ No	Anti-HBs	/ /	☐ Positive	☐ Negative
Pruritus	☐ Yes	☐ No	Anti-HBe	/ /	☐ Positive	☐ Negative
Palmar Erythema	☐ Yes	☐ No	IgM Anti-HBc	/ /	☐ Positive	☐ Negative
Hepatomegaly	☐ Yes	☐ No	IgG Anti-HBc	/ /	☐ Positive	☐ Negative
Splenomegaly	☐ Yes	☐ No	AST (SGPT)	/ /	_____	IU/L
Hepatic Encephalopathy	☐ Yes	☐ No	ALT (SGOT)	/ /	_____	IU/L
Coagulopathy	☐ Yes	☐ No	Platelet Count	/ /	_____	10^9/L
Variceal Hemorrage	☐ Yes	☐ No	Creatinine	/ /	_____	µmol/L
Spider Angiomata	☐ Yes	☐ No	eGFR	/ /	_____	mL/min/1.73m^2
Hepatic fibrosis	☐ Yes	☐ No	AFP	/ /	_____	ng/mL
Asterixis	☐ Yes	☐ No	HBV DNA	/ /	_____	IU/mL

Non-invasive tests for detection of cirrhosis	Date done	Result	
Aminotransferase/Platelet Ratio Index Score	____ / ____ / _____	☐ 1-2	☐ > 2
Transient Elastography	____ / ____ / _____	☐ ≤ 12.4 kPa	☐ ≥ 12.5 kPa
Imaging (UTZ/CT/MRI)	____ / ____ / _____	_____	

Does the client have **liver cirrhosis?** ☐ Yes ☐ No

If the client has liver cirrhosis, please indicate whether if it is: ☐ Compensated ☐ Decompensated

Did the client **developed hepatocellular carcinoma** following treatment? ☐ Yes ☐ No

Please identify if client has any of the following **co-infection**: ☐ Hepatitis C ☐ HIV

IV. TREATMENT

Is the client **eligible for treatment?** *(For assessment of eligibility, you may refer to the Physcian's Checklist)*

☐ Yes, the client will initiate treatment in this facility

☐ Yes, but the client refused treatment

☐ Yes, for initiation of treatment, the client will be referred to:
(please specify) _____

☐ No, the client does not meet the criteria for treatment and was advised to return for monitoring on:
(mm/dd/yyyy) ____ / ____ / _____

☐ Awaiting for laboratory results

☐ Enrolling this visit
☐ Continuing/refill
☐ Not on treatment
Reason if not on treatment: _____

Regimen: ☐ Tenofovir (TDF) ☐ Other: *(please specify)* _____

Date *(mm/dd/yyyy)*	# pills missed *(past 30 days)*	# of pills on hand	# of pills dispensed	Expected date of refill *(mm/dd/yyyy)*
____ / ____ / _____				____ / ____ / _____
____ / ____ / _____				____ / ____ / _____

If the patient's treatment was discontinued , please completely fill out this section.

Date discontinued: ____ / ____ / _____ **Reason:** *(D/C code)* _____ *(For code 6 & 7, please specify)* _____

Discontinuation codes (D/C): *1-Treatment Failure 2-Clinical progression 3-Patient Decision/Request 4-Compliance difficulties 5-Drug Interaction 6-Adverse Event (Specify) 7-Others (Specify) 8-Death*

V. CLINIC PERSONNEL PROVIDING INFORMATION

Clinic personnel and signature:

Telephone / cellphone number:

Email address:

Physician name and signature:

Telephone / cellphone number:

Email address:

Please send this accomplished form to natlstisurveillance@gmail.com or to Epidemiology Bureau - Department of Health , 2/F Rm. 209, Building 19, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila. Contact Nos: (02) 495-0513 & (02) 651-7800 loc. 2952