VIRAL HEPATITIS B CASE REPORT 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

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

Testing facility name: **Philhealth no.:**

Facility address: **Client contact #:**

Date of baseline HBsAg test: ____ / ____ / ________ **Client type:** ☐ Walk-in ☐ Referral ☐ In-patient ☐ Others

Unique Identifier Code [UIC]: *First two letters of mother's name* ☐☐ *First two letters of father's name* ☐☐ *Birth order* ☐☐ *Birth date (mm/dd/yyyy)* ☐☐☐☐☐☐☐☐

II. DEMOGRAPHIC DATA

First name: **Suffix:** *(Jr.,Sr.,III, etc.)*

Middle name: **Age in years:**

Last name: **Nationality:** ☐ Filipino ☐ Other: ____________

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

Self identity: ☐ Male ☐ Female ☐ Other **Number of children:** ☐☐ ☐ Not applicable

Current address: City/Municipality: Province: Region:

III. HISTORY OF EXPOSURE

Is the client's **birth parent/sibling(s)** positive for Hepatitis B?	☐ Yes	☐ No	☐ Unknown or N/A
Is the client's **spouse/partner** positive for Hepatitis B?	☐ Yes	☐ No	☐ Unknown or N/A
Does the client have history of **sharing needle and syringe** with others?	☐ Yes	☐ No	☐ Unknown or N/A
Does the client have history of **injecting drug** w/o physician's advice?	☐ Yes	☐ No	☐ Unknown or N/A
Has the client been **accidentally pricked by needles/sharps?**	☐ Yes	☐ No	☐ Unknown or N/A
Did the client **receive a tattoo**?	☐ Yes	☐ No	☐ Unknown or N/A
Was there a history of **sex with a <u>male</u> with no condom**?	☐ Yes	☐ No	☐ Unknown or N/A
Was there a history of **sex with a <u>female</u> with no condom**?	☐ Yes	☐ No	☐ Unknown or N/A
Does the client **pay (in cash or in kind) for sex**?	☐ Yes	☐ No	☐ Unknown or N/A
Does the client **accept payments (in cash or in kind) in exchange for sex**?	☐ Yes	☐ No	☐ Unknown or N/A
Was there a history of **employment abroad in the past 5 years**?	☐ Yes	☐ No	

IV. MEDICAL HISTORY

Is there a **family history of Hepatocellular Carcinoma (HCC) / primary liver cancer**?	☐ Yes	☐ No
Does the client have **hepatocellular carcinoma prior to treatment initiation?**	☐ Yes	☐ No
Does the client have **history of receiving blood/blood products**?	☐ Yes	☐ No
Does the client have **history of undergoing hemodialysis**?	☐ Yes	☐ No

If the client was **tested for HIV**, what was the result? ☐ Positive ☐ Negative ☐ Indeterminate/unable to get the result

If on antiretroviral therapy (ART), please specify: ______________________

If the client was **tested for Hepatits C,** what was the result? ☐ Positive ☐ Negative ☐ Unable to get the result

If on antiviral treatment, please specify: ______________________

Was the client **vaccinated for Hepatitis B**? ☐ Yes ☐ No

If yes, please specify:

First Dose	☐ Yes	☐ No	☐ Unknown
Second Dose	☐ Yes	☐ No	☐ Unknown
Third Dose	☐ Yes	☐ No	☐ Unknown

(Continue with clinical assessment for treatment eligibility ***using the Patient Care Form****.)*