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Fax # 1-855-934-5463 (WDGLine)

Confidential Hepatitis B Questionnaire – Page 1

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Please complete the following Information: **PHN:**

Name:_____ DOB: _____ Alias: _____ Gender:
Address: _____
Telephone: (H)_____ (W) or (Cell) if appropriate: _____
☐ Married ☐ Single ☐ Common-law *Family Doctor:*_____

For the following questions, please check the appropriate box(es) and fill in any further information requested.

1. **Does the client speak English?** ☐Yes ☐No If no, what language do they speak? _____

2. **Was the client born in Canada?** ☐Yes ☐No If no, *what country were they born?* _____
Date of Arrival to Canada: _____

3. **Is this the first time the client has been tested for Hep B?** ☐Yes ☐No
If no, when was the client last tested for Hepatitis B? Date:_____ Previous City: _____
Was the previous result □ Positive or □ Negative?

4. **Is the client a** ☐ Acute Case ☐ Carrier
(A carrier is defined as detection of HBsAg with a negative IgM anti-HBC, or presence of HBsAg persisting for over six months)
****Please Note:** *If there is only one positive HBsAg test on file for the client, Public Health will be requesting an additional test for HBsAg and IgM anti-HBc in six months time to confirm the carrier state.*

5. **Has the client been informed of the results of the blood work?** ☐Yes ☐No

6. ***For Females*: Is the client pregnant?** ☐Yes ☐No *If yes, what is the estimated due date?*_____
Is this the client's first child? □ Yes □ No *If yes, has the client been counselled on PEP for baby after delivery? □ Yes □ No*
Client's OB/midwife _____ Where is the client planning to give birth? _____

7. **Why was the test ordered?**
☐ Routine Screening ☐ Immigration screening ☐ Canadian Blood Services ☐ Pre-op for transplant ☐ Prenatal Screening
☐ Contact Tracing ☐ Treatment ☐ Co-diagnosis/co-infection with existing STI _____
☐ Symptoms – *please describe* _____

8. **What are the possible sources of infection?**

☐IV drug use	☐ Occupational exposure	☐ Multiple sex partners	☐No condom	☐sexual contact of case
☐Inhalation drug use	☐ Health care worker	☐Dialysis	☐Homosexual male	☐Household contact
☐Shared needles	☐ Born to case/carrier	☐ Tattoo	☐Acupuncture	☐Piercing
☐Organ/tissue transplant	☐Invasive surgical/dental/ocular procedure abroad		☐Received blood products abroad	
☐Born in endemic country *(please specify)* _____			☐Other: _____	

9. **Has the client ever donated blood?** ☐Yes ☐No If *yes, please provide date and location*: _____

10. **Has the client had a blood transfusion?** ☐Yes ☐No If *yes, please provide date and location*: _____
***Note:** If the client has ever donated blood or received a blood transfusion, they should be advised that under the Health Protection and Promotion Act, s.26, Public Health is required to report this information to Canadian Blood Services.*

11. **Has the client had any prior Hepatitis A vaccination?** ☐Yes ☐No
If yes, please provide dates: _____
If no, has the client been tested for Hepatitis A and shown to be immune? □ Yes □ No

***Note:** Clients with hepatitis B should be encouraged to receive hepatitis A vaccine which is available free of charge through the Ministry of Health high risk program. Vaccine can be ordered via the Public Health vaccine order form. http://www.wdgpublichealth.ca/?q=hppimm*

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Client Name: **PHN:**

12. **Are there any household or sexual contacts?** ☐Yes ☐No

Note: *Public Health must ensure all sexual and household contacts are tested and protected against acquiring Hepatitis B infection from the client.*

Please list all **sexual** and **household** contacts for the client: ****Please include copies of all blood work results***

Name	Date of Birth	Phone #	Relationship to client	Physician Name	Hepatitis B Bloodwork Results*	Dates of Hepatitis B vaccinations (if needed)
					Date: HBsAg - Anti-HBc - Anti-HBs - Titre:	1. 2. 3.
					Date: HBsAg - Anti-HBc - Anti-HBs - Titre:	1. 2. 3.
					Date: HBsAg - Anti-HBc - Anti-HBs - Titre:	1. 2. 3.
					Date: HBsAg - Anti-HBc - Anti-HBs - Titre:	1. 2. 3.
					Date: HBsAg - Anti-HBc - Anti-HBs - Titre:	1. 2. 3.
					Date: HBsAg - Anti-HBc - Anti-HBs - Titre:	1. 2. 3.

13. **What is the client's occupation?** ____ Employer ___________________________

**Healthcare workers should report to their occupational health department and regulatory body for further direction. Depending on service, the client may need to report their HBV status*

14. **Will the client be referred to a specialist?** ☐Yes ☐No

If yes: Specialist Name __________________________________ Phone # ____________________________

15. **Has the client been tested for HIV and Hepatitis C?** ☐Yes ☐No

*If yes: HIV result*____________________________ *Hepatitis C result*___________________________________

16. **Will you be counselling this client on Hepatitis B and how to prevent the spread of the infection to others?** ☐Yes ☐No

☐ *Please refer to the newly released Public Health Agency of Canada "Primary Care Management of Hepatitis B Quick Reference –Module 11"*

**Electronic version can be accessed on our website under Healthcare Providers – 'Hepatitis'* *www.wdgpublichealth.ca*

17. **Have you informed the client a Public Health Nurse may be contacting them?** ☐Yes ☐No

** A PHN may not contact the client if this form has been completed and/or the client has been referred to a specialist.*

Notes: ____

____

Physician Signature: **Date:**