



# Report of Notifiable Condition Hepatitis B virus or Related Death

South Australian Public Health Act 2011

**FAX (08) 7425 6696** completed report of Notifiable Condition Hepatitis B virus or Related Death form to the Communicable Disease Control Branch.

**PHONE 1300 232 272** (Mon – Fri 8:30am – 5pm) as soon as practicable and in any event within 3 days of suspecting or confirming a diagnosis.

## A CASE DETAILS (please print clearly and tick all applicable boxes)

Last name \_\_\_\_\_

Given name \_\_\_\_\_

Name of parent/carer (if applicable) \_\_\_\_\_

Residential Address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode

Phone (H) \_\_\_\_\_ Phone (M) \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  Transgender

**Is the person of Aboriginal or Torres Strait Islander origin?**  
For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes  
 Yes Aboriginal  Yes Torres Strait Islander  No

**Where was the person born?**  
 Australia  Overseas *Specify country:* \_\_\_\_\_

**Is the person a healthcare worker?**  
 Yes  No

**Is the person/caregiver aware of the diagnosis?**  
 Yes  No

**Date of death** (if applicable) \_\_\_\_/\_\_\_\_/\_\_\_\_

## B DISEASE TO NOTIFY (please tick whichever applies)

**In your clinical opinion does the person have**  Hepatitis B, acute or newly acquired infection in the past 24 months **OR**  
 Hepatitis B, chronic or infection of unknown duration

## C CLINICAL ASSESSMENT (please tick all that apply)

**Date of the current positive result** \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Positive pathology results received from**  
 Abbotts  APP  Clinpath  Healthscope  SAPath/IMVS  Other *Specify:* \_\_\_\_\_

**Hepatitis B surface antigen (HBsAg)**  Detected  Not detected  Not tested  Unknown

**Hepatitis B core IgM (IgM anti-HBc)**  Detected  Not detected  Not tested  Unknown

**Hepatitis B virus by nucleic acid testing (HBV DNA)**  Detected  Not detected  Not tested  Unknown

ALT results \_\_\_\_\_ U/L | Bilirubin results \_\_\_\_\_ umol/L | Date of tests \_\_\_\_/\_\_\_\_/\_\_\_\_

**Has the person had symptoms of acute hepatitis within the past 24 months?**  
 No  Unknown  Yes | *Specify symptoms:* \_\_\_\_\_ | Date of onset of symptoms \_\_\_\_/\_\_\_\_/\_\_\_\_

**Has the person had a negative hepatitis B surface antigen (HBsAg) test within the past 24 months?**  
 No  Not tested  Unknown  
 Yes | **Location of previous negative test**  South Australia  Interstate  Overseas | *Specify pathology provider (if known):* \_\_\_\_\_ | Date of test \_\_\_\_/\_\_\_\_/\_\_\_\_

**Has the person previously tested positive for hepatitis B?**  
 No  Unknown  
 Yes | **Location of previous positive test**  South Australia  Interstate  Overseas | *Specify pathology provider (if known):* \_\_\_\_\_ | Date of test \_\_\_\_/\_\_\_\_/\_\_\_\_

## D CLINICAL COMMENTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## E DOCTOR DETAILS (stamp acceptable)

Name \_\_\_\_\_

Address of practice/hospital \_\_\_\_\_

Postcode

Phone (Clinic) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please inform the person/caregiver you have notified SA Health

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www.sahealth.sa.gov.au/NotifiableDiseaseReporting

Revised March 2021





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Patient's last name \_\_\_\_\_ Patient's given name \_\_\_\_\_ Date of birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## F EPIDEMIOLOGICAL INFORMATION (please tick all that apply)

**The person's sexual partners in the last 24 months were:**  
 Male  Female  Male and Female

**Does the person have a history of injecting drug use?**  
 Yes, within the last 24 months  No  
 Yes but not within the last 24 months  Unknown

**Where was the infection likely to have been acquired?**  
 South Australia  
 Interstate  
 Overseas *Specify country:* \_\_\_\_\_

Has the person had any of the following risk exposures? (please tick all that apply)	Ever	Within the last 24 months
Sexual partner of the opposite sex with known HBV	<input type="checkbox"/>	<input type="checkbox"/>
Sexual partner of the same sex with known HBV	<input type="checkbox"/>	<input type="checkbox"/>
Household contact with known HBV	<input type="checkbox"/>	<input type="checkbox"/>
Perinatal transmission	<input type="checkbox"/>	<input type="checkbox"/>
Imprisonment	<input type="checkbox"/>	<input type="checkbox"/>
Tattoos	<input type="checkbox"/>	<input type="checkbox"/>
Ear or body piercing	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
Surgical or other invasive procedure	<input type="checkbox"/>	<input type="checkbox"/>
Dental surgery	<input type="checkbox"/>	<input type="checkbox"/>
Haemodialysis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/blood products/tissues in Australia	<input type="checkbox"/>	<input type="checkbox"/>
Blood/blood products/tissues overseas	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplantation in Australia	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplantation overseas	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare worker with no documented exposure	<input type="checkbox"/>	<input type="checkbox"/>
Occupational needlestick/biohazardous injury in a healthcare worker	<input type="checkbox"/>	<input type="checkbox"/>
Occupational needlestick/biohazardous injury in a non-healthcare worker	<input type="checkbox"/>	<input type="checkbox"/>
Non-occupational or unspecified needlestick/biohazardous injury	<input type="checkbox"/>	<input type="checkbox"/>
Other risk <i>Specify:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

**For acute hepatitis B or newly acquired infection in the last 24 months please provide further details about risk exposure/s.**  
 This can include but is not limited to date, location, nature of medical procedure or blood transfusion.

**Reason for testing (please tick all that apply)**

<input type="checkbox"/> Investigation of symptomatic hepatitis	<input type="checkbox"/> Prison screening	<input type="checkbox"/> Blood or organ donor screening	<input type="checkbox"/> Screening for other purposes
<input type="checkbox"/> Abnormal liver function tests	<input type="checkbox"/> Antenatal screening	<input type="checkbox"/> Occupational screening	<input type="checkbox"/> Contact of a case
<input type="checkbox"/> Occupational exposure	<input type="checkbox"/> Pre-operative screening	<input type="checkbox"/> STI screening	<input type="checkbox"/> Other <i>Specify:</i> _____

## G HOUSEHOLD AND SEXUAL CONTACTS

The treating doctor should identify all of the person's household and sexual contacts and offer testing using the following diagnostic tests:

- Hepatitis B surface antigen (HBsAg)
- Total hepatitis B core antibody (anti-HBc)
- Hepatitis B surface antibody (anti-HBs)

Hepatitis B vaccine should be offered to all non-immune household and sexual contacts.

Order hepatitis B vaccine through the routine vaccine ordering process. For further assistance contact the Vaccine Distribution Centre on telephone number (08) 7425 7139.

Further information about the public health management of hepatitis B can be obtained by speaking with the duty doctor at the Communicable Disease Control Branch on 1300 232 272.

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