Saskatchewan Health

Confidential Notification of
Hepatitis B, C and D

⇒ ALL AREAS MUST BE COMPLETED FOR MHO *(Please do not submit form to Saskatchewan Health.)*

A. Client Information

Format all dates as: **day/month/year** (dd/mm/yyyy)

Last Name	First Name & Middle Initial	Other Name/Maiden/Alias	HSN

Residence Address (street and apt no., FN community)	Nearest town / city	Postal Code	DOB __/__/____ Age ____	( ) Male ( )Female

Mailing Address (if different from above)	Phone # Home ____ Work ____	Workplace/Occupation	Name of Guardian (if minor)

Source of Referral	Date referred __/__/____	Reporting Physician & Phone Number	Client's Physician & Phone Number

Health Region (of Client's Residence)	Hospitalized ( ) Yes ( ) No	Hospital	Admission date __/__/____	Discharge date __/__/____	Date of Death __/__/____

B. Disease Information

( ) HEPATITIS B
( ) Carrier
( ) Case
( ) Unsure
( ) HEPATITIS C
( ) HEPATITIS D

Is client immunized for hepatitis B?
( ) Yes ( ) No ( ) Unk

Date immunized __/__/____

Meets Case Definition ( ) Yes ( ) No
Epi Linked ( ) Yes ( ) No
Onset of symptoms: __/__/____
Date of jaundice: __/__/____

Indicate all that apply: ( ) None
( ) nausea ( ) loss of appetite
( ) malaise ( ) dark urine
( ) fatigue ( ) other

Hepatitis B, C & D testing

Date Collected: __/__/____ Lab #____

Lab tests	Pos	Neg	Not Done
HBs Ag	( )	( )	( )
anti-HBs	( )	( )	( )
anti-HBc IgM	( )	( )	( )
core total	( )	( )	( )
HBe Ag	( )	( )	( )
anti-HBe	( )	( )	( )
PCR-Hep C	( )	( )	( )
anti Hep C IgG	( )	( )	( )
anti-HDV	( )	( )	( )

Related information

anti HAV IgG <pos> <neg> Not done
anti HAV IgM <pos> <neg> Not done
anti HTLV I/II <pos> <neg> Not done
other ____

Has previous testing been done?
( ) Yes ( ) No
If yes: When __/__/____
Where ____

C. Risk identification - Ask about all risks below answering Yes, No or Unknown to ALL categories

Risk Exposure Category – ask about ALL categories	Choose one - Y, N or Unk	Onset date of activity	Additional information required in comments
From or ever lived in an endemic region	( ) Yes ( ) No ( ) Unknown	N/A	
Injection drug use including steroids	( ) Yes ( ) No ( ) Unknown	__/__/____	
Tattoo, earpiercing, body piercing	( ) Yes ( ) No ( ) Unknown	__/__/____	(Specify which procedure)
Blood/blood product recipient, hemophilic (Factor VIII, anti-D immune globulin, etc.)	( ) Yes ( ) No ( ) Unknown	__/__/____	(Specify type of blood product, date and location where received)
Recent dental work/surgery/acupuncture, medical needle electrodes (EEG, EMG)	( ) Yes ( ) No ( ) Unknown	__/__/____	(specify)
Sexual contact with person of same sex	( ) Yes ( ) No ( ) Unknown	__/__/____	
Sexual contact of a known case or person at risk	( ) Yes ( ) No ( ) Unknown	__/__/____	(name and address of diagnosed case)
Multiple sexual partners (2 or more in past 6 months)	( ) Yes ( ) No ( ) Unknown	__/__/____	
Perinatal transmission	( ) Yes ( ) No ( ) Unknown	N/A	
Recipient of artificial insemination	( ) Yes ( ) No ( ) Unknown	__/__/____	(specify)
Household contact	( ) Yes ( ) No ( ) Unknown	__/__/____	(specify)
Spent time in jail (use if no other identified risk factor)	( ) Yes ( ) No ( ) Unknown	__/__/____	(where)
Other	( ) Yes ( ) No ( ) Unknown	__/__/____	(specify)
No identifiable risks for acquiring infection	( ) Yes ( ) No ( ) Unknown	__/__/____	(specify)
Transmission risk: blood or blood product donor	( ) Yes ( ) No ( ) Unknown	__/__/____	(product, date, location where donated)
Transmission risk: tissue/ organ donor (eg sperm, kidney)	( ) Yes ( ) No ( ) Unknown	__/__/____	(type of donation, date, location where donated)
Transmission risk: case is a health care provider	( ) Yes ( ) No ( ) Unknown	N/A	(specify type of provider)

D. Client's ethnocultural background

( ) Caucasian ( ) Black ( ) Indo-Asian ( ) Hispanic ( ) Asian Aboriginal: ( ) on reserve ( ) off reserve ( ) Other ____	Country of Birth ( ) Canada ( ) Other(specify) ____	Date of Arrival in Canada __/__/____

Public Health MHO or Designate signature ____ Date: __/__/____