Hepatitis B Notification Form

Government of Saskatchewan

PANORAMA

Panorama QA complete: ☐ **Yes** ☐ **No**
Initials:

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name:	***FOR PUBLIC HEALTH OFFICE USE ONLY:***
Location:	**Service Area:**
Attending Physician or Nurse:	**Date Received:**
Address:	**Panorama Client ID:**
Phone number:	**Panorama Investigation ID:**

B) CLIENT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _______ Health Card Province: ________ Health Card Number (PHN):	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other Gender Identity: ☐ Transgender Male-to-female ☐ Transgender Female-to-male ☐ Undifferentiated ☐ Other (specify)	Phone : ☐ Primary Home: ☐ Mobile contact: ☐ Workplace: ☐ Alt Contact: Name: ________________________ Relationship: _________________________
Place of Employment/School:	Email Address:	Preferred Communication Method: ☐ Home ☐ Work ☐ E-mail ☐ Text

Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description

Mailing (Postal address):

Street Address or FN Community (Primary Home):

C) IMMIGRATION INFORMATION

Country Born In: ___________________________

Country Emigrated from: ___________________________ Arrival Date: YYYY / MM / DD OR Arrival Year YYYY

D) DISEASE EVENT HISTORY

Staging: ☐ Acute ☐ Chronic ☐ Unknown

E) SIGNS & SYMPTOMS

Description	No	**Yes Date of onset**	**Description**	No	**Yes Date of onset**
Arthralgia			Nausea		
Asymptomatic			Pain - Abdominal		
Fever			Rash		
Jaundice			Stool – light		
Lethargy (fatigue, drowsiness, weakness, etc)			Urine – dark		
Loss of appetite (anorexia)			Vomiting		
Malaise			Weight loss		
Myalgia (muscle pain)			Other – specify		

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Panorama Client ID: ___________
Panorama Investigation ID: ___________

F) RISK FACTORS (Please complete *all* Risk Factors –specify dates as needed) – Legend: N – No, NA – Not asked, U – Unknown

DESCRIPTION	Yes Start Date	N, NA, U	Add'l Info
Contact – Hepatitis B	YYYY / MM/DD		
Exposure – Blood and body fluids (not otherwise listed) (Add'l Info)	YYYY / MM/DD		
Exposure - Invasive body art (e.g. tattoo, body piercing, scarification)	YYYY / MM/DD		
Occupation – Health Care Worker – IOM Risk Factor			
Risk Behavior – Sharing injection drug equipment	TE		
Risk Behavior – Sharing non-injection drug equipment	TE		
Sexual Behaviour – More than 2 sexual partners in past 3 months	TE		
Sexual Behaviour – MSM	TE		
Sexual Behaviour – Sex with a known case (Add'l Info)	YYYY / MM/DD		
Sexual Behavior – Sex with person from endemic country (Add'l Info)			
Sexual Behavior – Sex with person who injects drugs	TE		
Special Populations – Correctional Facility resident			
Special Population – From or residence in an endemic country			
Special Population – Infant born to infected mom			
Special Population – Pregnancy			
Special Population – Self-reported indigenous			
Substance Use – Alcohol			
Substance Use – Injection Drug Use (including Steroids)			
Substance Use – Illicit non-injection drug use			
Travel – Outside of Canada (Add'l Info)	YYYY / MM/DD		
Other risk factor (Add'l Info)			
Medical Treatment - Blood, blood product or tissue recipient (Add'l Info)	YYYY / MM/DD INTERVENTION		
Medical Treatment Other (transplant, surgery, dental, oscopy, artificial insemination etc.) (Add'l Info)	YYYY / MM/DD INTERVENTION		
*Blood, blood product, tissue or transplant **donor***	*Document referral in Interventions and complete Appendix K – Referral to CBS, and upload into Document Management*		

G) UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts:________ (number of contacts that the individual cannot name)

Include known contacts on the following pages

Case Name:

Page _____ of _______

Hepatitis B – Contacts

Please complete **all** sections.

Please include information on additional contacts on a separate sheet

A) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _______ HSN: ___________________________________	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ alternate phone: Relationship:	**e-mail Address:**	
Place of Employment/School:	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is contact Hep B positive?** ☐ Yes ☐ No ☐ Unknown	
Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home):		
Exposure Dates: 1st YYYY / MM / DD to YYYY / MM / DD **Exposure Type**: ☐ Sexual ☐ Household ☐ Sharing Injection/ Non-injection Drug Equipment		
Will the testing Physician/Nurse **follow-up** this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Has the contact been vaccinated for Hep B in the past? ☐ Yes ☐ No	**Comments**:	

B) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _______ HSN: ___________________________________	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ alternate phone: Relationship:	**e-mail Address:**	
Place of Employment/School:	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is contact Hep B positive?** ☐ Yes ☐ No ☐ Unknown	
Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home):		
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Will the testing Physician/Nurse **follow-up** this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Has the contact been vaccinated for Hep B in the past? ☐ Yes ☐ No	**Comments**:	