STD CLINIC PROCEDURES
HEPATITIS B VACCINATION

1. All patients receive Hepatitis B vaccination education sheet (Hepatitis B the Only STD With a Vaccine) and self-administered form (HHSA:DC-31a) when they register at desk. Education handout has English on one side and Spanish on flip side. Self-administered HHSA:DC-31a is available in either English or Spanish.

2. Patient completes self-administered HHSA:DC-31a and turns it in to clerical staff with the rest of registration paperwork. The clerical person should check that the patient has completed the form (both front and back). However, completion of the form is voluntary and if the patient refuses to complete the form the clerk should not persist.

3. Clinician/nurse reviews form (HHSA:DC-31a) to determine if patient has indicated Yes (wants vaccine), No (declines vaccine) or Not Sure.

- Accepted:
  a. All patients are given the Vaccine Information Statement (VIS), the current CDC form (12/16/1998; English or Spanish), and assisted in reviewing the form so they fully understand the risks and benefits of the vaccine.
  b. Indicate STD clinic site (Rosecrans, East, Oceanside or South Bay)
  c. Have patient read Hepatitis B Vaccine Administration/Consent Form (HHSA:DC-30) (English or Spanish) and sign under “Patient Signature”.
  d. If patient is less than 19 years of age have the patient review the Vaccines For Children (VFC) form, and ask whether patient meets any of the criteria listed; if yes, indicate on HHSA:DC-30; if no circle “does not qualify”. There is no need to complete the VFC form for any patient.
  e. Check Vaccine Given box on form HHSA:DC-31a and initial
f. Clinician/nurse indicates the VIS Form Date (found on lower left corner, side 2, of CDC handout) on line after patient’s signature and date.
g. Clinician/nurse prepares and administers vaccine, and records date, Manufacturer and lot #, site of vaccination, and signature on the HHSA:DC-30 form.
h. Patient is given an “expedited appointment” reminder card which indicates need to return for next dose after the minimum time interval date:

   Dose 1 = 0 days
   Dose 2 = 28 days (1 month or 4 weeks) after dose 1
   per Dr. Gunn you may give dose 2 if the patient appears in clinic up to 3 days before day 28
   Dose 3 = 112 days (4 months or 16 weeks) after dose 1 and at least 56 days (2 months or 8 weeks) after dose 2. Please note: there must be a minimum of 4 months or 16 weeks between dose 1 and dose 3 and at least two months or eight weeks between dose 2 and dose 3.

FOR EXAMPLE:

Mr. and Mrs. Smith come to the clinic together; they both receive dose #1 on January 1, 1999; Mr. Smith returns for dose 2 on February 1, 1999; he is not eligible for dose #3 until May 1, 1999 (needs 4 months between dose #1 and #3). Mrs. Smith returns for dose #2 on March 15, 1999; she is eligible for dose #3 any time after May 15, 1999 (which will be 5.5 months after dose #1 but only 2 months after dose #2).
• **Not Sure:**
  a. Address concerns/questions of patient; after final decision follow “Accepted” or “Declined” procedures.
  b. As stated above, patients who have numerous questions or seem to be unsure about accepting the vaccine may be told: “You seem to have many concerns about the vaccine so I recommend you take these materials home and review them and not get the vaccine at this time.” It is not expected that clinic staff will spend an inordinate amount of time to convince a patient to receive the vaccine.

• **Declined:**
  a. Re-offer vaccine (unless reason for decline is: “had all 3 shots” or “had Hepatitis B”).
  b. If the patient still declines, reconfirm the reason on form HHSA:DC-31 by checking Vaccine Declined box; indicate reason and initial.

• **PUT PATIENT LABEL ON ALL FORMS (HHSA:DC-30 and HHSA:DC-31)**
  - **HHSA:DC-30** stays in medical record whether the patient accepts or declines vaccine; if the patient gets tested and is found to be hepatitis B positive a line should be drawn through the consent form signature area so no more doses of vaccine will be administered.
  - **HHSA:DC-31** is set aside for Hepatitis B data entry staff (at East, Oceanside and South Bay) these forms will be sent via interdepartmental mail to: Paula Murray, MS-P511B)

4. Patients returning for vaccine doses 2 and 3 will be expedited through the clinic since they will not **usually** require a clinician exam (see below for when an exam is suggested at time of dose #3).
  a. Return patients will again sign the appropriate line on the HHSA:DC-30 and be offered another copy of the CDC VIS.
  b. Clinician/nurse will complete appropriate line of HHSA:DC-30.
c. All STD patients receiving dose #2 or dose #3 of the hepatitis B vaccine will have the most recent Dose 2/3 form (HHSA:DC-32 7/1999) completed by the nurse at the time the dose is administered.

d. If the patient received dose #1, or doses #1 and #2, somewhere else (such as at their private M.D. or in the military) they need to complete the Hepatitis B Vaccine risk assessment form (HHSA:DC-31a 5/99) to accompany the Dose #2/Dose #3 form.

e. Please be sure to indicate whether it is a #2 or #3 dose being administered by marking the appropriate statement:
   
   Vaccine Dose #2
   Vaccine Dose #3

f. The Dose 2/3 form has two check-off boxes which should be marked if they apply to that particular dose:

   a) Patient referred by a CDI for hepatitis B vaccine: this indicates that the patient is a close contact to a person known to have infectious hepatitis B and has been referred in by one of the Field Staff for testing and vaccination.
   
   b) Patient started the series at a different project site.
      Location: this indicates that the patient began the hepatitis series at one of several community sites which is participating in the Hepatitis Immunization Program; for whatever reason they are unable to complete the series where they began and have been referred to the STD Clinic for completion.

   If either or both apply, please mark the box. For b, list where the patient began the series, i.e. jail, drug treatment program, etc.

g. Since patients coming back for only dose #3 may not have had an STD examination for several months some new items have been added to trigger STD evaluation of high-risk individuals.

   For all patients receiving dose #3 who have not seen the clinician at this visit, the person administering the vaccine needs to answer the questions at the bottom of the form:

   Is the patient High-Risk? [injection drug user (IDU), commercial sex worker (CSW), men having sex with men (MSM), HIV infected (900), or have history of bacterial STD (gonorrhea, chlamydia or syphilis only) in past 5 years]
   
   Yes
   No
Is the patient less than (<) 20 years old?
Yes
No

If YES to any of the above, obtain a urine specimen for CT, LE (males) and GC. This will require that a pink or blue (clinic visit) sheet be created to document the visit date and the test results.

On the Dose #2/#3 (HHSA:DC-32) form complete the Check tests ordered area:

CT    GC    LE Test (do while patient waits)
circle the result:
   NEG, trace, 1+, 2+

If LE test is trace, 1+ or 2+ send patient to clinician for evaluation and treatment. The clinician will then complete the clinic visit form and a CT/GC lab form after a more thorough history is taken. If the LE test is negative, or not done (for females), the nurse will complete the clinic visit form (see Appendix B) and prepare a CT/GC lab form (see Appendix A.)

h. Miscellaneous reminders:

1) Be sure there is a patient sticker attached to each and every form. If stickers are unavailable during the clinic, the patient name, id number, date of birth, sex, and race must be handwritten on the form.

2) Indicate which clinic the form comes from: Rosecrans, East, Oceanside, or SouthBay

3) Please take care to clearly indicate whether the patient received the dose or not. Many forms come through with no indication of whether or not the vaccine was actually given.

i. All Hepatitis B Vaccine forms should be sent via interdepartmental mail at the end of each clinic (except Rosecrans where the forms are picked up) to:

Paula Murray
Hepatitis B Program
MS P511-B

j. Clinician/nurse will complete Hepatitis B Vaccine Dosage #2 & #3 Dispense Form (HHSA:::DC-32 7/99), and will place it in HBV data entry box (At East and
Oceanside these forms will be sent via interdepartmental mail to: Paula Murray, MS – P511B).

Miscellaneous Issues:

1. **Walk-in requests for Hepatitis B vaccine:**

   Patients walking in to the STD clinic requesting only Hepatitis B vaccine (do not confuse these with STD patients returning for dose 2 or 3) should be referred to community clinics. The standard response is: “Hepatitis B vaccine is offered as part of the STD examination and treatment service – it is not available for the general public at this facility”.

2. **Adverse Reactions:**

   In the unlikely event that a patient calls or walks into the STD clinic complaining of a suspected adverse reaction to the Hepatitis B vaccine the following guidelines should be followed:

   a. The patient (caller) should be triaged to a nurse or clinician along with the patient’s medical chart.
   b. The nature of the complaints should be documented in a progress note and an assessment made of the seriousness of the complaint.
   c. The patient should be advised to go to an emergency care facility if the symptoms seem to be life-threatening or serious.
   d. If the complaints are not life-threatening the patient should be advised to seek medical care with his/her usual medical care provider. If the patient does not have a provider he/she should be given the address and telephone number of community clinics.
e. If the patient states that the County of San Diego is responsible for the medical problem, the patient may file a claim. The patient should be given the number of the Claims Division to request a form: 531-4900. No promise of assistance from the STD clinic or from the County of San Diego # should be implied.

If the patient insists on speaking to someone else, the following list indicates the appropriate staff (in order of who to contact first) to refer the patient to:

1. Public Health Nurse Manager
2. Bob Gunn, M.D.
3. Michele Ginsberg, M.D.

3. **Clinician discretion:**
   At the discretion of the clinician, based on the needs of the patient, it may be decided that a patient should not be given the vaccine at this time. Each clinician will make these decisions after review of the patient’s individual medical history and condition and weighing the risk of vaccination against the risk of acquiring hepatitis B.

4. **Clinic Capacity Issues:**
   If clinic capacity for the day has been reached and patients are being triaged, the triage nurse will determine whether patients requesting Hepatitis B vaccine dose 2 or 3 can be seen within clinic hours. The PHN Manager will be contacted to provide vaccine, if possible, before these patients are turned away.

9/24/1999
HEPATITIS B VACCINE
CONSENT FORM

Review self-administered form (DC-31) with patient. If patient has accepted vaccine continue with this form and administer vaccine. If patient has declined, re-offer vaccine and address any concerns of the patient. If patient still declines, confirm reason on form DC-31.

VFC Category (for children <19 years old): 1 2 3 4 Does not qualify

VACCINE ADMINISTRATION

<table>
<thead>
<tr>
<th>Hepatitis B</th>
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<tbody>
<tr>
<td><strong>Dose #</strong></td>
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<td>#1</td>
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<td>#2</td>
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<td>#3</td>
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**Site =** RD or LD - left or right deltoid **First initial, last name, title (e.g., S. Smith, RN)**

I have been given a copy and have read, or have had explained to me, the information contained in the vaccine information statement about the disease and vaccine indicated below. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the Hepatitis B vaccine be given to me. Also, I understand that if I do not return for doses 2 and 3, I may be contacted.

Me han dado una copia y he leído, o me han dado una explicación sobre la información contenida en el folleto que habla sobre la enfermedad de hepatitis B y su vacuna. He tenido la oportunidad de hacer preguntas, las cuales han sido contestadas a mi completa satisfacción. Entiendo los beneficios y los riesgos de la vacuna y pido que me den esta vacuna. Entiendo si no regreso para las vacunas 2 y 3, es posibilidad que se comuniquen conmigo.

Hepatitis B

<table>
<thead>
<tr>
<th><strong>Patient Signature</strong></th>
<th><strong>Date</strong></th>
<th><strong>VIS Form Date</strong></th>
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THIS FORM TO REMAIN IN MEDICAL RECORD
Please complete this form. All information is CONFIDENTIAL and will help identify the services you need.

NAME: __________________________

DATE OF BIRTH: ________________

SEX:  □ MALE  □ FEMALE

TODAY’S DATE: ________________

1. What is the reason for your visit? (check all that apply)
   □ Have symptoms such as discharge, sore, rash or ______________________
   □ No symptoms-want a check up and/or tests
   □ Told or think you might have been exposed to an STD
   □ Told to come in by an (STD) investigator
   □ Want hepatitis services
   □ Other: ____________________________________________________

2. Have you had sex in the last 3 months?  □ Yes  □ No
   With how many persons?  1  2  3  4  5  more than 5

3. My sex partners are:  □ Men  □ Women  □ Both

4. How many people have you had sex with during your lifetime?
   (circle the closest number)
   If you answer none, turn the page over and go to question #8

   0  1  2  3  4  5  10  15  25  30  50  75  100  More than 100

5. When you have sex, do you use a condom?
   □ Always  □ Most of the time  □ Sometimes
   □ Rarely  □ Never

6. Have you ever paid for sex, or traded sex for money or drugs?
   □ Yes  □ No

7. Check the box by any disease you have had in the last 5 years:
   □ Syphilis (bad blood)  # of times____
   □ Gonorrhea (clap)  # of times____
   □ Chlamydia  # of times____
   □ Trichomonas (“trick”)  # of times____
   □ Sex Warts
   □ Herpes
   □ HIV
   □ Women – infection in your tubes/womb (PID)  # of times____
   □ Men – burning or drip from penis (not gonorrhea or chlamydia)

TURN THE PAGE OVER

Patient Sticker Here

□ Rosecrans  □ Central Region
□ South Region  □ North Coastal

HHSA: DC-31 (3/01)  County of San Diego, Health and Human Services Agency
8. Did you have a blood transfusion before 1992? □ Yes □ No

9. Have you ever injected drugs? □ Yes □ No

10. If you answered YES to #9, please complete the following:
   a) Did you ever share needles? □ Yes □ No
      If YES: □ Most of the time □ Sometimes □ Rarely □ Only once

   b) Did you ever share “works”? □ Yes □ No
      If YES: □ Most of the time □ Sometimes □ Rarely □ Only once

   c) How old were you the first time you injected?___________

   d) Have you injected drugs in the last 12 months? □ Yes □ No

   e) Check the box which best describes your level of injection drug use:
      □ Less than 10 times in your lifetime
      □ Used for 1 year or less
      □ Used for _____ years
      □ Current user: Have been using for _____ years

11. Have any of your sex partners used injection drugs? □ Yes □ No □ Not sure
    If Yes, who was it? (check all that apply)
    □ current sex partner □ past sex partner

12. Have you had sex with someone who has hepatitis B or C? □ Yes □ No □ Not sure

13. Have you ever been in jail or prison? □ Yes □ No

14. How often do you cross the US-Mexico border?
    □ Every day □ 2-6 times/week □ once a week □ once a month
    □ 2-6 times/year □ once a year □ less than once a year □ never

15. How long do you usually stay on the Mexican side of the border?
    □ I do not stay on the Mexican side □ 1-3 days □ more than 3 days

16. Are you interested in starting the hepatitis B vaccine today? □ Yes □ No □ Not Sure
    If NO, why not? □ I’ve already had all 3 vaccine shots
    □ I’ve had Hepatitis B
    □ Other reason ________________________

OFFICE USE ONLY

Hep B Vaccine Given □_________(initials)
Hep B Vaccine Not Given □_________(initials)
Patient referred by CDI for hep B testing and/or vaccine
Patient started vaccine at_____________________

OFFICE USE ONLY

Counselor_______
Clinician_______
Nurse_______
IDU □ 900 □
MSM □ CSW □
HBV/HCV contact□
IDU contact □
QUESTIONARIO DEL RIESGO DE ENFERMEDADES VENEREAS/HEPATITIS

Por favor complete este formulario. La información es completamente CONFIDENCIAL y nos ayudará a identificar los servicios que usted necesita.

NOMBRE: ________________________________ FECHA DE NACIMIENTO: _________
SEXO: □ MASCULINO □ FEMENINO FECHA DE HOY: _______________________

1. Cuál es la razón de su visita? (marque todo lo que aplique)
   □ Tiene síntomas tales como desecho, inflamación, picazón o____________________
   □ No tiene síntomas. Solo quiere un examen.
   □ Le dijeron o piensa que pueda haber estado expuesto a alguna enfermedad venerea.
   □ Un empleado de la clínica (Investigador) le dijo que viniera.
   □ Quiere servicios sobre la hepatitis.
   □ Other ______________________

2. Ha tenido relaciones sexuales en los últimos 3 meses?  □ Sí  □ No
   Con cuántas personas? 1 2 3 4 5 más de 5

3. Mis parejas de sexo son:  □ Hombres □ Mujeres □ Ambos

4. Con cuántas personas durante toda su vida usted ha tenido relaciones sexuales (marque con un círculo el número más cercano)? Si contestó zero, pase a la pregunta #11
   0 1 2 3 4 5 10 15 25 30 50 75 100 Más de 100

5. Cuándo tiene relaciones sexuales, usa usted un condón?
   □ Siempre □ La mayoría de las veces □ Algunas veces
   □ Raramente □ Nunca

6. Ha pagado dinero a alguien para tener relaciones sexuales?  □ Sí □ No

7. Marque los cuadros que indican las enfermedades que haya tenido en los últimos 5 años
   □ Sífilis _______ veces □ Verrugas Venéreas
   □ Gonorrea _______ veces □ VIH
   □ Clamidia _______ veces □ Herpes
   □ Tricomoniasis _______ veces
   □ Mujeres - infección en los tubos/útero (Enfermedad Inflamatoria Pélvica) _______ veces
   □ Hombres - ardor o goteo del pene (no gonorrea o clamidia) _______ veces

CONTINUE AL DORSO
□ Rosecrans □ Central Region
□ South Region □ North Coastal
County of San Diego, Health and Human Services Agency
8. Ha tenido transfusión de sangre antes del año 1992?  □ Sí □ No

9. Alguna vez se ha inyectado drogas?  □ Sí □ No

10. Si es SÍ, por favor complete lo siguiente:
   a) Ha compartido las agujas con otra persona?  □ Sí □ No
      Sí es SÍ:  □ Todo el tiempo □ Algunas veces □ Raramente □ Solamente una vez
   b) Ha compartido “works” con otra persona?  □ Sí □ No
      Sí es SÍ:  □ Todo el tiempo □ Algunas veces □ Raramente □ Solamente una vez
   c) Que edad tenía usted la primera vez que se inyectó? __________________
   d) Durante los últimos 12 meses, se ha inyectado drogas?  □ Sí □ No
   e) Marque el cuadro que más describe su nivel de uso de drogas inyectables:
      □ Menos de 10 veces en su vida □ Usé por____años
      □ Usé por un año o menos □ Actualmente usando por____años

11. Ha tenido algún compañero de sexo que se ha inyectado drogas?
      □ Sí □ No □ No Estoy Seguro
      Si es SÍ, quien fue? (marque todo lo que aplique)
      □ Pareja Actual □ Ex-Pareja

12. Ha tenido relaciones sexuales con alguien que tenga hepatitis B o C?
      □ Sí □ No □ No Estoy Seguro

13. Alguna vez ha estado encarcelado?  □ Sí □ No

14. Cuantas veces usted cruza la frontera entre Estados Unidos y Mexico?
      □ Cada Dia □ 2-6 veces a la semana □ Una vez a la semana □ Una vez al mes
      □ 2-6 veces al año □ Una vez al año □ Menos que una vez al año □ Nunca

15. Usualmente cuanto tiempo, se hospeda en el lado Mexicano?
      □ No me hospedo en el lado Mexicano □ 2-6 veces al año
      □ 1 – 3 días □ Más de 3 días
      □ Una vez al mes

16. Está usted interesada(o) en empezar la vacuna de la Hepatitis B hoy?
      □ Sí □ No □ No Estoy Seguro
      Si es NO, por qué no? (marque todo lo relativo a usted)
      □ Ya he recibido las 3 vacunas □ Yo he tenido la Hepatitis B
      □ Otra razón __________________

OFFICE USE ONLY
□ Hep B Vaccine Given _______(initials) □ Patient referred by CDI for hep B testing and/or vaccine
□ Hep B Vaccine Not Given _______(initials) □ Patient started vaccine at_______________

HHSA:DC-31s (3/01)
Instructions for STD / Hepatitis Risk Questionnaire

The following is a summary of hepatitis services within the STD Clinic and how to use the new and improved STD/HEPATITIS RISK QUESTIONNAIRE. The form has been designed to assist in the identification of high-risk clients and the services they are eligible to receive. REMINDER: All clients should be offered hepatitis B vaccine.

TESTING SERVICES:

Clients at high-risk, or possibly at high-risk, for hepatitis B or hepatitis C should be offered serological testing. The recommendation for testing may be made by the Clinician, the Nurse or the HIV Counselor.

The STD/HEPATITIS RISK QUESTIONNAIRE (HHSA:DC-31a 1/2001) has been revised to assist in the identification of those clients who meet testing and hepatitis A vaccination criteria. The boxes on the right-hand side of the revised form need to be completed for every patient by whichever staff member sees patient first (usually the counselor). Codes in the boxes are defined below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>HBV testing</td>
</tr>
<tr>
<td>C</td>
<td>HCV testing</td>
</tr>
<tr>
<td>Avac</td>
<td>Hepatitis A vaccine</td>
</tr>
<tr>
<td>☐</td>
<td>Female clients only</td>
</tr>
<tr>
<td>Ø</td>
<td>Client not high-risk for HBV or HCV or hepatitis A vaccine; these clients should not be offered these services; this box will be the one most frequently checked.</td>
</tr>
</tbody>
</table>

For the last box on the back side of the STD/HEPATITIS RISK QUESTIONNAIRE all staff who review the form should place their initials on the appropriate line.

<table>
<thead>
<tr>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselor</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>Clinician</td>
</tr>
</tbody>
</table>

If, through discussion with the patient, you discover that they have high-risk behaviors which they did not indicate on the STD/HEPATITIS RISK QUESTIONNAIRE do not make any changes to the patient-completed entries. Instead, indicate the risk (or risks) by checking the appropriate box(es) as described below:
Based on this information you may then offer the patient any hepatitis services for which they qualify (see specific criteria below). Be sure to indicate this risk information on the Hepatitis Lab Form.

The HIV Counselors will be reviewing most STD/HEPATITIS RISK QUESTIONNAIRES, however, clinicians and nurses should review each form and initial.

The following criteria identify those patients eligible for testing services:

**Both Hepatitis B & Hepatitis C testing:**
- Injection drug user (past or present)
- Sex partner of injection drug user
- Sex partner of an individual known to be chronically infected with hepatitis
- Female commercial sex worker

**Hepatitis B testing only:**
- Men who have sex with men

**Hepatitis C testing only:**
- Received a blood transfusion or other blood products prior to 1992

These criteria identify most high-risk individuals, however, at the discretion of the clinician, other patients may be offered hepatitis B or C testing.

**Other testing guidelines:**

- Patients who have tested indeterminate for HCV should not be re-tested until six months from the date of the indeterminate test.
- If a patient has previously been tested (for hepatitis B or C) in the STD Clinic and tested negative (not infected) but continues to engage in high-risk activity, they may have the test repeated six months from the date of the first test.
The hepatitis services offered in the STD Clinic are for STD patients – patients should not be referred to the clinic for confirmatory testing of their hepatitis B or C status from other clinics/agencies/blood bank, etc. Patients referred for “confirmation” of their hepatitis (B or C) status should not be tested.

VACCINATION SERVICES:

Hepatitis B Vaccine:

Every patient of the STD Clinic should be offered hepatitis B vaccine. Currently, 72% of eligible patients (not already vaccinated or not already immune) accept the hepatitis B vaccine. Unfortunately, the highest-risk patients, IDU and MSM, accept at lower rates of 67% and 68% respectively. A few extra minutes spent exploring why high-risk clients decline the vaccine would provide valuable information (to be documented on the “HIGH-RISK CLIENTS WHO DECLINE HEPATITIS SERVICES WORKSHEET”) and might result in more of these clients accepting the vaccine.

Return rates for doses 2 and 3 are not as high as anticipated, 49% return for dose 2 and 25% return for dose 3. Please spend a moment educating patients that they are not fully protected until they receive all the doses. You might also emphasize how expensive the vaccine is if they ever wanted to finish the series through a private physician or health care plan.

Hepatitis A Vaccine:

Hepatitis A vaccine is offered to patients who meet the following criteria:

- Men who have sex with men
- Injection drug user (past or present)
- Any individual who is chronically infected with HBV or HCV
Instructions for Hepatitis B Vaccine Dose 2 & 3 Form

This memo is to clarify the use of the DC-32 (5/99) Hepatitis B Vaccine Dose #2 and Dose #3 Form (attached for reference). This form should replace all previous versions of the Dose 2/3 form.

1. All STD patients receiving dose #2 or dose #3 of the hepatitis B vaccine should have this form completed by the nurse at the time the dose is administered.

2. If the patient received dose #1, or doses #1 and #2, somewhere else (such as at their private M.D. or in the military) they need to complete the Hepatitis B Vaccine risk assessment form (HHSA:DC-31a 5/99) to accompany the Dose #2/Dose #3 form.

3. Please be sure to indicate whether it is a #2 or #3 dose being administered by circling the appropriate statement (marked by X on the attached form):
   - Vaccine Dose #2
   - Vaccine Dose #3

4. As described in the memo of May 24, 1999 this new form has two check-off boxes which should be marked if they apply to that particular dose:
   a) Patient referred by a CDI for hepatitis B vaccine
   b) Patient started the series at a different project site.
      Location_____________

   If either or both apply, please mark the box. For b, list where the patient began the series, i.e. jail, drug treatment program, etc.

5. Since patients coming back for only dose #3 may not have had an STD examination for several months some new items have been added to trigger STD evaluation of high-risk individuals.

   For all patients receiving dose #3 who have not seen the clinician at this visit, the person administering the vaccine needs to answer the questions at the bottom of the form:
Is the patient High-Risk? [commercial sex worker (CSW), men having sex with men (MSM), HIV infected (900), or have history of bacterial STD in past 5 years]
   Yes
   No

Is the patient less than (<) 20 years old?
   Yes
   No

If YES to any of the above, please obtain a urine specimen for CT, LE (males) and GC.

Complete the **Check tests ordered** area:
CT  GC  LE Test *(do while patient waits)*
circle the result:
   NEG, trace, 1+, 2+

If LE test is trace, 1+ or 2+ send patient to clinician for evaluation and treatment.

6. Miscellaneous reminders:

1) Be sure there is a patient sticker attached to each and every form. If stickers are unavailable during the clinic, the patient name, id number, date of birth, sex, and race must be written on the form.

2) Indicate which clinic the form comes from: Rosecrans, East, Oceanside, or SouthBay

3) Please take care to clearly indicate whether the patient received the dose or not. Many forms come through with no indication of whether or not the vaccine was actually given.
HEPATITIS B VACCINE
DOSE #2

☐ Patient referred by a CDI for Hepatitis B vaccine.
☐ Patient started the series at a different project site. Location: ______________________
☐ Patient started with pregnancy testing.

HEPATITIS B VACCINE
DOSE #3

☐ Patient referred by a CDI for Hepatitis B vaccine.
☐ Patient started the series at a different project site. Location: ______________________
☐ Patient started with pregnancy testing.

For Nurse or Clinician Use Only:

1. Is the patient High-Risk? (CSW, MSM, IDU, 900, or have history of bacterial STD in past 5 years)
   ☐ Yes ☐ No

2. Is the patient < 20 years old?
   ☐ Yes ☐ No

If 1 or 2 above is YES obtain a urine specimen for CT, GC and LE (males) testing.

☐ Notify receptionist of testing to obtain DC-245 (Blue) or DC-246 (Pink) and LCR lab slip (Green)

☐ Complete the LCR lab slip and check which tests were ordered below:
   ☐ CT ☐ GC

☐ While patient waits, perform LE test and mark result below:
   ☐ NEG – Submit urine specimen for testing. No need to send patient to clinician.
   ☐ TRACE – Send patient to clinician for evaluation and treatment
   ☐ 1+ - Send patient to clinician for evaluation and treatment
   ☐ 2+ - Send patient to clinician for evaluation and treatment
**High-Risk Clients Who Decline Hepatitis Services**

Clinic Staff: Please complete this form whenever a high-risk patient declines any hepatitis service recommended for their risk group. Indicate the criteria which qualify them for each service. Thank you.

1. **TESTING for hepatitis B:**
   - MSM  IDU  partner IDU  partner chronic hepatitis (B or C)  female CSW
   - Other__________
   - Had hepatitis B/is chronic HBV
   - Afraid to know test result
   - Does not want blood drawn
   - Other reason______________
   - Recently tested
   - Not worried about hepatitis
   - Does not want extra tube of blood drawn

2. **TESTING for hepatitis C:**
   - IDU  partner IDU  partner chronic hepatitis (B or C)  female CSW
   - blood transfusion before 1992  Other__________
   - Knows they are infected
   - Afraid to know test result
   - Does not want blood drawn
   - Other reason______________
   - Recently tested
   - Not worried about hepatitis
   - Does not want extra tube of blood drawn

3. **VACCINATION for hepatitis A:**
   - MSM  IDU  chronic HBV  chronic HCV  Other__________
   - Already had vaccine series
   - Had hepatitis A
   - Not worried about hepatitis
   - Other reason__________________
   - Doesn’t like shots/needles
   - Will get from regular M.D.
   - Other reason__________________

4. **VACCINATION for hepatitis B:**
   - MSM  IDU  HCV  partner IDU  partner chronic hepatitis (B or C)  Other__________
   - Already had vaccine series
   - Had hepatitis B
   - Not worried about hepatitis
   - Other reason__________________
   - Doesn’t like shots/needles
   - Will get from regular M.D.
   - Other reason__________________

**FORM COMPLETED BY:**
- Counselor _____(init.)
- Clinician _____(init.)
- Nurse _________ (init.)

**MARK STD CLINIC SITE:**
- Rosecrans
- Central Region PHC
- North Coastal PHC
- South Region PHC

**PATIENT STICKER HERE**

Return this form to: Hepatitis Services P-511B
I verify that the above information is correct and I consent to testing and treatment for sexually transmitted diseases by the County of San Diego, Health & Human Services Agency.

Signature:_____________________________________                Date:________________________             Witness:___________________________

**If Seen Within 30 Days:**
- Persistent Symptoms   Y    N
- New Symptoms            Y    N

**Describe________________**

**ANY MEDICATIONS PAST 2 WEEKS?**
- Antibiotics    Y    N     Name:_________________________________
- Other Meds Including OTC Items    Y     N

**Existing Medical Conditions:**

**Sex Since Last Visit?**
- No       Former       New
- Partners Treated
- Yes      No        Unknown

**Physical Examination**
- Oropharynx
  - WNL
  - WNL
  - Ulcer
  - Erosions
  - Inflamed
  - Other

**Extranogenital Nodes**
- WNL
  - WNL
  - Cervical
  - Axillary
  - Epithelial
  - Other

**Inguinal Nodes**
- WNL
  - Enlarged
  - Left
  - Right
  - Tender
  - Other

**Penis**
- WNL
  - Uncircumcised
  - Discharge
  - Ulcer
  - Vesicle
  - Warts
  - Balanitis
  - Rash
  - Molluscum

**Scrotal Contents**
- WNL
  - Left
  - Right
  - Tender
  - Swollen
  - Mass
  - Hydrocele

**ORAL**
- Not Done
- WNL
- Ulcer
- Discharge
- Discharge
- Ulcer
- Other

**Analyzing**
- Not Done
- WNL
- Ulcer
- Other

**Tips on Physical Findings**

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**CLINIC SITE:**
- Rosecrans
- Central
- South
- N. Coastal

**TYPE OF VISIT**
- New
- Follow-Up
- Massage
- Hep B Vaccine
- Case Management
- CT Retest

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**REFERRAL DISEASE**
- CT
- Syphilis
- NGU
- Chlamydia
- PID
- Herpes
- Warts
- Hepatitis
- Syphilis

**SEX IN PAST 3 MONTHS?**
- Yes    No
- LSE:__________________
- Total # Of Partners In Past 3 Months________________
- # of New Partners_______

**PREDISPOSING SITES**
- Oral
- Genital Insertive
- Genital Receptive

**PARTNER GENDER**
- Female
- Male
- Both

**RISK FACTORS (Lifetime)**
- IDU
- Share Works
- Last Use___________
- Drug______________
- Partner IDU Y N
- CSW Y N
- Sex with CSW Y N
- Male Partners Y N
- Condom Use Y N

**TRAVEL (Past 60 days)**
- Hawaii/Asia/Pacific
- Mexico/Central/South America
I verify that the above information is correct and I consent to testing and treatment for sexually transmitted diseases by the County of San Diego, Health & Human Services Agency.

Signature:_____________________________________                Date:________________________             Witness:___________________________

If Seen Within 30 Days:
Persistent Symptoms   Y    N
New Symptoms            Y    N
Describe________________

ANY MEDICATIONS PAST 2 WEEKS?
Antibiotics    Y    N     Name:_________________________________
Other Meds Including OTC Items    Y     N
_________________________________
_________________________________

Existing Medical Conditions:
_________________________________
_________________________________

Sex Since Last Visit?
No O Former       New Partners Treated
Yes        g Unknown

Comments

PHYSICAL EXAMINATION

Oro-Pharynx
WNL
Ulcer
Exudate
Inflamed
Other

Skin
WNL
P & P Rash
Other Rash
Folliculitis
Intertrigo
Molluscum
Scabies
Other

Abdomen
WNL
Tenderness
Rebound
Mass
Other

Pubic Hair
WNL
Crabs/Nits
Other

Vulva/Vagina
WNL
Erythema
Abnormal Discharge
Ulcer
Vesicle
Warts
Rash
Menses
Other

Cervix
WNL
Ectopy
Discharge
Fibrae
Ulcer
Vesicle
Other

Bimanual
WNL
Motion Tenderness
Adnexal Tenderness
Adnexal Fullness
Mass
Let
Right
Other

Rectal
WNL
Not Done
WNL
Warts
Discharge
Ulcer
Other

Comments On Physical Findings
### STAT LABORATORY
- None Ordered
- Wet Mount: WNL
- Wet prep: Clue +
- WBC: 10
- Amine: Neg
- Hyphae: Neg
- Trich: Neg
- Darkfield: Neg
- Smear: Neg
- Pregnancy: Neg
- Other: 

### ROUTINE LABORATORY
- Gonorrhea Culture
  - Cervix: N P U
  - Urethral: N P U
  - Anal: N P U
  - Throat: N P U
  - Urine: N P U
- Chlamydia
  - Cervix: N P U
  - Urine: N P U
- Syphilis
  - RPR Qual: N R U
  - TPPA: N R U
- Hepatitis B
  - Core Ag: NR
  - Surface Ag: NR
- HIV
  - ELISA: NR
  - IFA: NR
  - WB: NR

### HIV PRE AND POST TESTING
- HIV Test Counseled: Yes
- Accepts Testing: No
- Post Test Session: 
- Counselor: 
- Date: 

### CLINICAL IMRESSION
- No Disease Pending Results
- Bacterial Vaginosis: HSV First
- Chancroid: HSV Recurrent
- Chlamydia-Cervix: HPV Old Dx
- Chlamydia-Urethral: HPV New Dx
- Contact NGU/CT: Molluscum
- Contact GC: MCV
- Contact Syphilis: Non-STD Dermatosis
- Contact Trich: PID NOS
- Contact Other: PID CT
- Crabs: PID GC
- Folliculitis: Scabies
- GUD-NOS: Syphils 10
- GC Anal: Syphils 20
- GC Cervical: Syphils 30
- GC Pharynx: Syphils 40
- GC Urethral: Syphils 45
- Hepatitis: 

### HEPATITIS B VACCINE IM
- 1st Dose: None
- 2nd Dose: Bicillin (IM)
- 2.4 mu Only
- Series of 3 Injections
- 1st 2.4 mu
- 2nd 2.4 mu
- 3rd 2.4 mu
- Ceftriaxone 250 mg IM X 1
- Spectinomycin 2 Gm IM X 1
- Azithromycin 1 GM PO X 1
- Cefixime 400 mg PO X 1
- Ofloxacin 400 mg PO X 1
- Metronidazole 500 mg PO X 1
- 2 gm PO X 1 Stat Dose
- BID X 7 Days
- Cotrim 2 BID X 7 Days
- Doxycycline 100 mg PO BID
- 7 Days
- 10 Days
- 14 Days
- 28 Days

### HEPATITIS A VACCINE
- 1st Dose: Erythromycin 250 mg PO QID
- 2 Days
- 3 Days

### WRITTEN RX
- Acyclovir 200mg 400mg 800mg
- Telquin 250mg 500mg
- Famvir 125mg 250mg
- Wart Treatments
  - Anti-Ectoparasitics
    - Permethrin Cream
    - Permethrin Rinse
  - Anti-Fungal
    - Oral
    - Topical
- Aldara
- Condylox
- Other

### COMMENTS
- Wet Mount: WNL
- Wet prep: Clue +
- WBC: <10, >10
- Amine: Neg
- Hyphae: Neg
- Trich: Neg
- Darkfield: Neg
- Smear: Neg
- Pregnancy: Neg
- Other: 
- Cervical Cytology: Not Done
- WNL: LG Sil
- Inflammation
- Atypia: Hg Sil
- Carcinoma
- Reactive Cellular Changes
- Other: 

### ALLERGIES
- None Known
- Penicillin
- Other: 

### FOLLOW-UP
- None/PRN
- Re-Evaluate On: 

### REFERRED TO
- Primary Care
- Emergency Room
- PCP
- Family Planning
- ESI
- Other

### COUNSELING
- Medication
- Condom
- Handouts
- Temporary Abstinence
- Partner Referral
- Partner cards given

### NP/PA: __________________________ RN: __________________________ MD: ________________
HEPATITIS B CORE ANTIBODY (Anti-HBc)
LAB TESTING

Policy:
To determine the baseline rate of past infection with hepatitis B for STD clinic patients the San Diego Hepatitis Project offered hepatitis B core antibody (Anti-HBc) testing to patients who routinely have blood drawn in the STD clinic (syphilis serology is routinely offered to all clients). Those specimens testing positive for Anti-HBc will also be tested for hepatitis B surface antigen (HbsAg).

Testing was done during the month of February 1998.

Procedure:
1. The clerk places a patient label on the copy of the Examination for Hepatitis lab form.

2. All patients having blood drawn in clinic for RPR or HIV are eligible to have hepatitis B core antibody testing done.

3. The nurse explains to each patient who is having blood drawn that hepatitis B core antibody testing can be done on the blood specimen if the patient agrees. The nurse explains that the testing is being offered for one month in conjunction with the availability of hepatitis B vaccine at the STD clinic.

4. If the patient agrees to have hepatitis B core antibody testing done, the nurse completes the Examination for Hepatitis lab form (Lab 22).

5. The nurse submits the lab form with the patient’s blood specimen (only one tube of blood is needed for RPR or HIV and hepatitis B core antibody) to the Public Health Lab (PHL).

6. PHL will conduct hepatitis B core antibody test; all specimens reactive will then have additional testing done (HbsAG). All final results will be sent to the STD Clinic for posting in medical records; results should be given to the patient when they return or mailed if they have not returned within one month.
EXAMINATION FOR HEPATITIS

San Diego County Public Health Laboratory
3851 Rosecrans St. P.O. Box 8522
San Diego, CA  92186-5222  (619) 692-8500
C.R. Peter, Ph.D., Chief

CHECK TESTS REQUESTED:

☐ HEP B  ☐ HEP C

☐ (NON-IDU) ☐ HEP C EIA ONLY (IDU)

Patient Name & ID:

Zip Code:

Date of Birth:  Age:  Ethnicity:  Sex:  Date of Specimen:

Physician Name/Initials: ___________________________  Phone: ______________________

Billing:  ☐ Medi-Cal # ___________________  ☐ SOFP # ___________________  ICD-9 Code ______

SOURCE OF SPECIMEN: (Check only one)

☐ Blood  ☐ Serum  ☐ Other (special study) ______________________________

TYPE OF VISIT: (Check only one)

☐ New  ☐ Follow-up  ☐ HIV Only  ☐ Hep B vaccine #2/#3

REASON FOR VISIT/REFERRAL (Check only one)

☐ Self  ☐ Family Plan  ☐ Hep B Vaccine Returnee  ☐ Partner  ☐ Outreach Worker  ☐ CDI
☐ Drug Treatment Ctr.  ☐ HIV ATS Counselor  ☐ Other ____________________  ☐ MD/Health Clinic
☐ Unknown

KNOWN CONTACT (Check only one)

☐ No Known Contact  ☐ Hep B  ☐ Hep C  ☐ Other ____________________

RISK GROUP: (Check all that apply)

☐ None  ☐ IV Drug User  ☐ Male-male
☐ Multiple (> 3 in 3 mos) Partners  ☐ Sex Partner IVDU  ☐ Bisexual
☐ Prostitute/Prostitute Contact  ☐ Sex Partner Bisexual Man
☐ Blood Transfusion prior to 1992  ☐ Unknown

CLINIC SITE/ORIGIN OF REQUEST:

☐ Rosecrans P-511 D 001  ☐ North Coastal Region N-514 007  ☐ EIP/T-Cell
☐ Central Region S-516 003  ☐ South Region S-518 008  ☐ Epidemiology
☐ Alternative Test Site (Location) ___________________  ☐ Drug Court (Location) __________
☐ Methadone Clinic (Location) ___________________  ☐ Perinatal Hepatitis B
☐ Teen Mobile Clinic
☐ Other ______________________________

DATE RECEIVED: