

Hepatitis A

COUNTY

FOR STATE USE ONLY

#

___/___/___ case report

confirmed

presumptive

___/___/___ interstate

suspect

date investigation initiated _____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

_____ language spoken _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner

Physician _____

ELR

Name _____

Phone _____ Date ___/___/___
(first report) m d yy

Primary M.D. _____

Phone _____ (if different) OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC
 yes no unknown

DATE OF BIRTH ___/___/___
m d yy

or, if unknown, AGE _____

PLACE OF BIRTH
 USA
 other _____

RACE
 White American Indian or Alaska native
 Black unknown
 Asian refused to answer
 Native Hawaiian or Pacific Islander other _____

Worksites/school/day care center

Occupations/grade

BASIS OF DIAGNOSIS

CLINICAL DATA

DIAGNOSIS DATE ___/___/___
m d yy

Symptomatic? yes no unknown

if yes, ONSET DATE (first s/s) ___/___/___
m d yy

Jaundiced yes no ___/___/___

Hospitalized from hepatitis yes no ___/___/___
admit date

Hospital name: _____

Died from hepatitis yes no

Date of death ___/___/___

Pregnant yes no ___/___/___
due date

REASON FOR TESTING (check all that apply)

- Symptoms of acute hepatitis
- Screening of asymptomatic patient with reported risk factors
- Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- Prenatal screening
- Evaluation of elevated liver enzymes
- Blood/organ donor screening
- Followup testing for previous marker of viral hepatitis
- Unknown
- Other _____

LABORATORY TESTS

Lab name: _____

Date of blood draw ___/___/___
m d yy

pos. neg. pending not done

IgM anti-HAV

total anti-HAV

HBsAg

IgM anti-HBc

total anti-HBc

anti-HBs

HBV DNA (PCR)

HBeAg

Anti-HCV

Anti-HCV signal-to-cutoff ratio

RIBA

HCV RNA (PCR)

HCV genotype _____

Other

Has the patient previously tested HBsAg-positive?

yes no unknown

if yes, when? ___/___/___
m d yy

Upper limit normal

Date of test
m/d/yy

(list reference value from lab slips)

ALT (SGPT) _____

AST (SGOT) _____

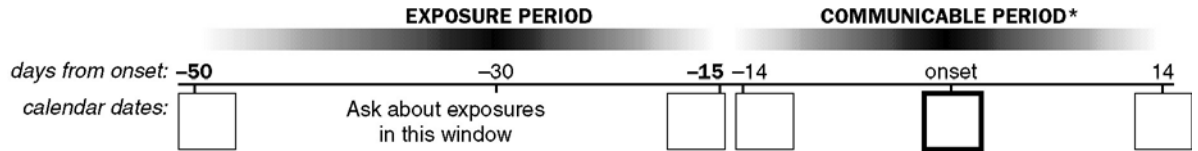
Bilirubin _____

other tests (specify)



INFECTION TIMELINE

Enter onset date (of first sx) in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



EPI LINKAGE

During the 2–6 weeks prior to onset, was the patient:

associated with a known outbreak

If yes, was the outbreak:

y n

foodborne, associated with an infected food handler

foodborne, not associated with an infected food handler

waterborne

source not identified

a close contact of an infectious **confirmed** or **presumptive** case

If yes, was this case reported? yes not yet

Specify nature of contact: household sexual child cared for by this patient

baby sitter of this patient playmate other _____

Specify food item _____

If yes to any question, specify relevant names, dates, places, etc.

Is the case aware of anyone else with signs or symptoms of hepatitis? yes no

If yes, give names, contact information, and other details.

IMMUNIZATION HISTORY

Did patient ever get any doses of hepatitis A Vaccine (not IG)? yes no unknown

If yes, provide details (dates, type of vaccine, etc.)

Vaccine Type	No. Doses	Date (m/d/y)	Provider/Phone	Verified	
				Y	N
_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>

Did patient ever receive immune globulin? yes no unknown

If yes, date of last dose (m/d/y) ___/___/___

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Check all that apply. Provide relevant details (nature of contact, names, dates, places, etc.) *Name suspect or reported cases, even if reported in another county or state.

no risk factors could be identified patient could not be interviewed

In the 2–6 weeks prior to symptom onset:

yes no

- a daycare attendee or employee
- b household member attends/works at day care center
- c ate raw/uncooked shellfish
- d ate at public gatherings
- e employed as a food handler during **2 weeks** prior to symptom onset or while ill
- f foreign travel in 3 months prior to symptom onset
if yes, where _____
- g household member with foreign travel in 3 months prior to symptom onset
if yes, where _____

yes no

- h any sexual contact if yes
number of male sexual partners
 0 1 2–5 >5 unknown
number of female sexual partners
 0 1 2–5 >5 unknown
- i uses street drugs but does not inject
- j injects drugs not prescribed by doctor
if yes, primary drug injected (select only one):
 Methamphetamine/Speed
 Heroin
 Cocaine
 Speedball (cocaine and heroin together)
 Other _____
- k other risk _____



PATIENT'S NAME ▶

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

Case education provided? yes no unknown if yes, date ____/____/____

PROPHYLAXIS

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Prophylaxis Recommended?
_____	_____	_____	____/____/____ <small>m d y</small>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> yes by proxy <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> immune <input type="checkbox"/> insignificant <input type="checkbox"/> NA exposure If yes, date recommended: ____/____/____ <small>m d y</small>
Prophylaxis given: <input type="checkbox"/> Referred to HCP <input type="checkbox"/> Refused <input type="checkbox"/> IG <input type="checkbox"/> Vaccine <input type="checkbox"/> None						Date prophylaxis given (if applicable): ____/____/____ <small>m d y</small>

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Prophylaxis given: <input type="checkbox"/> Referred to HCP <input type="checkbox"/> Refused <input type="checkbox"/> IG <input type="checkbox"/> Vaccine <input type="checkbox"/> None						Date prophylaxis given (if applicable): ____/____/____ <small>m d y</small>

Personal hygiene appears good adequate poor unknown

During the 2 weeks prior to onset of symptoms or while ill, did the patient prepare food for any public or private gatherings? yes no

If the case is a food handler, works/attends daycare, or is a HCW with direct patient contact, provide job description, dates worked during communicable period, supervisor's name and phone number, etc.

Site or job description	Dates worked while communicable	Supervisor's name and telephone number
_____	00/00/00 – 00/00/00	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IG recommended to non-household contacts yes no

Public announcement recommended yes no

Environmental inspection needed yes no

If yes, date: _____

Notes

ADMINISTRATION

Hepatitis A April 2008

Case report sent to OHS on ____/____/____

Completed by _____ Date Completed _____ Phone _____ Investigation sent to OHS on ____/____/____