

Hepatitis C

_____ COUNTY

FOR STATE USE ONLY

___/___/___ case report

confirmed

___/___/___ interstate

presumptive

suspect

Chronic Case

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

Black

Asian

Native Hawaiian or Pacific Islander

American Indian or Alaska native

unknown

refused to answer

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 _____

LAB 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)



PATIENT'S NAME >

[Empty box for patient name]

PATIENT HISTORY / RISK FACTORS

patient could not be interviewed no risk factor identified

yes no unk

- a Received a blood transfusion prior to 1992
- b Received an organ transplant prior to 1992
- c Received clotting factor concentrates produced prior to 1987
- d Ever on long-term hemodialysis
- e Employed in a medical or dental field involving direct contact with human blood
- f Ever a contact of a person who had hepatitis
If yes, type of contact:
g sexual
- h household (non-sexual)
- i Other _____

yes no unk

- j Ever injected drugs not prescribed by a doctor even if only once
- j If yes, primary drug injected (select only one):
 Heroin Methamphetamine/Speed
 Cocaine Speedball (cocaine & heroin together)
 Other _____
- k Year of most recent injection drug use (if applicable): _____
- l Ever incarcerated
- m Ever had a sexually transmitted disease

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

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

Ask about other potential contacts (sexual, needle-sharing, etc.) within the period of communicability. no other contacts identified

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	Tested?
_____	_____	_____	____/____/____ <small>m d y</small>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes by proxy If yes, date: ____/____/____ <small>m d y</small>	• Tested for HCV? • <input type="checkbox"/> referred to HCP <input type="checkbox"/> yes <input type="checkbox"/> no • tested: ____/____/____ <small>m d y</small>
_____	_____	_____	____/____/____ <small>m d y</small>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes by proxy If yes, date: ____/____/____ <small>m d y</small>	• Tested for HCV? • <input type="checkbox"/> referred to HCP <input type="checkbox"/> yes <input type="checkbox"/> no • tested: ____/____/____ <small>m d y</small>
_____	_____	_____	____/____/____ <small>m d y</small>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes by proxy If yes, date: ____/____/____ <small>m d y</small>	• Tested for HCV? • <input type="checkbox"/> referred to HCP <input type="checkbox"/> yes <input type="checkbox"/> no • tested: ____/____/____ <small>m d y</small>
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Identify other potential concerns; provide details:
recent blood/plasma donation yes no unknown

NOTES:

ADMINISTRATION

Chronic Hepatitis C April 2008

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