Hepatitis A

Orpheus ID

☐ confirmed
☐ presumptive
☐ suspect
☐ no case

Name _____ COUNTY_____
LAST, first, initials (a.k.a.)

Address _____ Special housing _____
Street City Zip

Phone number _____ / _____ _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

ALTERNATIVE CONTACT

Name _____ Phone(s) _____
LAST, first,initials home (H), work (W), cell (C), message

DEMOGRAPHICS

DOB ____/____/____
m d y

if DOB unknown, AGE _____

Sex ☐ female ☐ male

Language
_____

Country of birth
_____

Worksites/school/day care center
_____

Occupation/grade _____

RACE (***check all that apply***)

☐ White
☐ Black
☐ Asian
☐ Pacific Islander
☐ American Indian/Alaska Native
☐ unknown
☐ other_____

HISPANIC
☐ Yes ☐ No
☐ unknown ☐ declined

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)

☐_____
name and phone number

PMD Lab-fax
MDx Lab-phone
ER Lab-other
ICP HCP
Lab-ELR

Reporter Type (circle one)

☐_____
name and phone number

PMD Lab-fax
MDx Lab-phone
ER Lab-other
ICP HCP
Lab-ELR

☐ Ok to contact patient (only list once)

Local epi name_____
Date report received by LHD ____/____/____
LHD completion date ____/____/____

BASIS OF DIAGNOSIS

CLINICAL DATA Diagnosis date ____/____/____

Symptomatic? ☐ yes ☐ no ☐ unk
if yes, ONSET DATE (first s/s) ____/____/____

Jaundiced ☐ yes ☐ no ____/____/____

Pregnant ☐ yes ☐ no ____/____/____
due date

Hospital Name:_____

Hospitalized from hepatitis ☐ yes ☐ no ____/____/____
admit date

Died from hepatitis ☐ yes ☐ no ____/____/____
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
☐ Born between 1945-1965
☐ Unknown ☐ Other _____

LABORATORY TESTS

Lab Name:_____ Date of blood draw ____/____/____

		pos.	neg.	not. done	unk
A	IgM anti-HAV	☐	☐	☐	☐
	total anti-HAV	☐	☐	☐	☐
B	HBsAg	☐	☐	☐	☐
	IgM anti-HBc	☐	☐	☐	☐
	total anti-HBc	☐	☐	☐	☐
	anti-HBs	☐	☐	☐	☐
	HBV DNA (PCR)	☐	☐	☐	☐
	HBeAg	☐	☐	☐	☐
C	anti-HCV	☐	☐	☐	☐
	Anti-HCV signal-to-cutoff ratio _____				
	HCV RNA (PCR)	☐	☐	☐	☐
	HCV genotype _____				

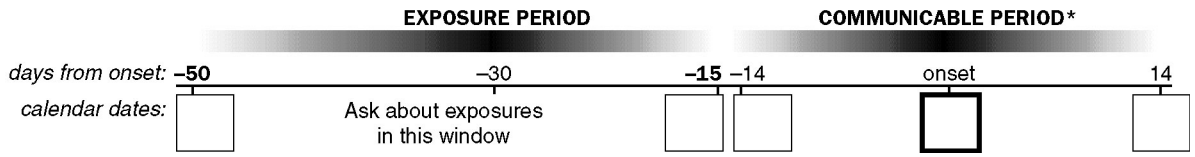
Upper limit normal
(list reference value from lab slips)

ALT (SGPT) _____ _____
AST (SGOT) _____ _____
Bilirubin _____ _____

CASE'S NAME _____

INFECTION TIMELINE

Enter onset date in heavy box. Count back to figure the probable exposure period. Ask about risk questions in this time period.



Interviewed ☐ yes ☐ no Interview date(s) _____ Interviewed by _____

Who ☐ patient ☐ provider ☐ parent ☐ other

Reason not interviewed (choose one)
☐ not indicated ☐ unable to reach ☐ out of jurisdiction ☐ deceased
☐ refused ☐ physician interview ☐ medical record review

RISKS

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.

yes no ref unk

☐ ☐ ☐ ☐ foreign travel in 3 months prior to symptom onset
if yes, where_____

☐ ☐ ☐ ☐ household member with foreign travel in 3 months prior to symptom onset
if yes, where_____

☐ ☐ ☐ ☐ daycare attendee or employee

☐ ☐ ☐ ☐ household member attends/works at daycare center

☐ ☐ ☐ ☐ employed as a food handler during **2 weeks** prior to symptom onset or while ill

☐ ☐ ☐ ☐ ate at public gatherings

☐ ☐ ☐ ☐ ate raw/uncooked shellfish

☐ ☐ ☐ ☐ ate any frozen berries or frozen pomegranate seeds?
if yes, provide product info and where purchased
_____

☐ ☐ ☐ ☐ consumed any smoothies?
if yes, provide details on if smoothies were homemade or store bought
_____

yes no ref unk

☐ ☐ ☐ ☐ close contact of infectious confirmed or presumptive case
if yes, nature of contact
☐ household ☐ sexual
☐ child cared for by this patient
☐ baby sitter of this patient
☐ playmate ☐ other _____

☐ ☐ ☐ ☐ any sexual contact
if yes, number of male sexual partners
☐ 0 ☐ 2-5 ☐>5 ☐ unk
if yes, number of female sexual partners
☐ 0 ☐ 2-5 ☐>5 ☐ unk

☐ ☐ ☐ ☐ uses street drugs, but does not inject

☐ ☐ ☐ ☐ injects drugs not prescribed by a doctor

CONTACT MANAGEMENT

HOUSEHOLD ROSTER

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
		☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual			___/___/___	___/___/___	___/___/___	☐Y ☐N
		☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual			___/___/___	___/___/___	___/___/___	☐Y ☐N
		☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual			___/___/___	___/___/___	___/___/___	☐ Y ☐N

CASE'S NAME

FOLLOW-UP

Case education provided? ☐ yes ☐ no ☐ unk if yes, date ___/___/___

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

if yes, give names contact information and other details

_____

_____

Has the case previously been immunized against the disease? ☐ yes ☐ no ☐ unk

if yes,

Vaccine Type	*No. Doses*	*Date* (m/d/y)	*Provider/Phone*	*Verified* Y	N
_____	____	___/___/___	_____	☐	☐
_____	____	___/___/___	_____	☐	☐
_____	____	___/___/___	_____	☐	☐

Did the case ever receive immuglobulin (IG)? ☐ yes ☐ no ☐ unk

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 ☐ unk

If the case was 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 00/00/00 — 00/00/00	Supervisor's name and phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Environmental inspection needed? ☐ yes ☐ no

Prophy recommended to non-household contact? ☐ yes ☐ no

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Case report sent to OHA on ____/____/____

Completed by _____ Date _____ Phone _____

Investigation sent to OHA on ____/____/____