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

DATE OF BIRTH ____/____/____
m d yy

or, if unknown, AGE _____

PLACE OF BIRTH
☐ USA
☐ other _____

HISPANIC
☐ yes ☐ no ☐ unknown

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 ____/____/____

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

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

Hospital name:_____

Died from hepatitis ☐ yes ☐ no
Date of death ____/____/____

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	☐	☐	☐	☐
RIBA	☐	☐	☐	☐
HCV RNA (PCR)	☐	☐	☐	☐

Anti-HCV signal-to-cutoff ratio

_____

HCV genotype _____

Other

_____

	Upper limit normal	Date of test m/d/yy
ALT (SGPT) _____	_____	___/___/____
AST (SGOT) _____	_____	___/___/____
Bilirubin _____	_____	___/___/____

(list reference value from lab slips)

other tests (specify)

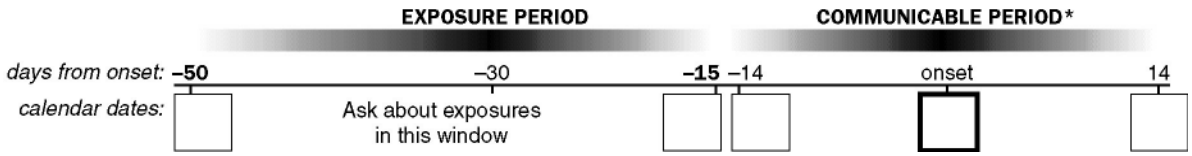
_____ _____ ___/___/____

_____ _____ ___/___/____

_____ _____ ___/___/____

INFECTION TIMELINE

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



*lasts at most 7 days after jaundice begins

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
_____	_____	____/____/____	_____	☐	☐
_____	_____	____/____/____	_____	☐	☐
_____	_____	____/____/____	_____	☐	☐

Did patient ever receive immune globulin? ☐ yes ☐ no ☐ unknown

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

*Name suspect or reported cases, even if reported in another co

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**

Interviewed: ☐ yes ☐ no Date: _____

Other sources of information: ☐ provider ☐ medical record review ☐ other specify: _____

In the 2—6 weeks prior to symptom onset:

yes no

☐ ☐ daycare attendee or employee

☐ ☐ household member attends/works at day care center

☐ ☐ ate raw/uncooked shellfish

☐ ☐ ate at public gatherings

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

☐ ☐ 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 _____

yes no

☐ ☐ 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

☐ ☐ uses street drugs but does not inject

☐ ☐ injects drugs not prescribed by doctor

if yes, primary drug injected (select only one):

☐ Methamphetamine/Speed

☐ Heroin

☐ Cocaine

☐ Speedball (cocaine and heroin together)

☐ Other_____

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 ____/____/____ (m d y)
Located? ☐ yes ☐ no
Education Provided? ☐ yes ☐ yes by proxy ☐ no
Prophylaxis Recommended? ☐ yes ☐ no ☐ immune ☐ insignificant exposure ☐ NA
If yes, date recommended: ____/____/____ (m d y)
Prophylaxis given: ☐ Referred to HCP ☐ Refused ☐ IG ☐ Vaccine ☐ None
Date prophylaxis given (if applicable): ____/____/____ (m d y)

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unty or state.

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 00/00/00 – 00/00/00	Supervisor's name and telephone number
______	______	______
______	______	______
______	______	______
______	______	______

IG recommended to non-household contacts ☐ yes ☐ no **Environmental inspection needed** ☐ yes ☐ no

Public announcement recommended ☐ yes ☐ no If yes, date: ______

Notes

ADMINISTRATION

Case report sent to OHS on ____/____/____

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