Hepatitis C

Chronic Case

COUNTY

date investigation initiated ____/____/____

FOR STATE USE ONLY #

___/___/___ case report ☐ confirmed ☐ presumptive

___/___/___ interstate ☐ suspect

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 _____

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

PATIENT'S NAME ▸

PATIENT HISTORY / RISK FACTORS

☐ patient could not be interviewed ☐ no risk factor identified ☐ no investigation required

yes	no	unk	ref	
☐	☐	☐	☐	Received a blood transfusion prior to 1992
☐	☐	☐	☐	Received an organ transplant prior to 1992
☐	☐	☐	☐	Received clotting factor concentrates produced prior to 1987
☐	☐	☐	☐	Ever on hemodialysis
☐	☐	☐	☐	Employed in a medical or dental field involving direct contact with human blood
☐	☐	☐	☐	Ever a contact of a person who had hepatitis

if yes, type of contact:

☐	☐	☐	☐	sexual
☐	☐	☐	☐	needle
☐	☐	☐	☐	household (non-sexual)
☐	☐	☐	☐	other ______________________________

yes	no	unk	ref	
☐	☐	☐	☐	Has the patient ever injected drugs not prescribed by a doctor even if only one or a few times

Year of most recent injection drug use (if applicable): __________

☐	☐	☐	☐	Ever incarcerated
☐	☐	☐	☐	Ever treated for a sexually transmitted disease
☐	☐	☐	☐	Is the patient a man who has ever (even if only once) had sex with another man.

Indicate number of lifetime male sexual partners

☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ unknown

Indicate number of lifetime female sexual partners

☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ unknown

CASE–CONTACT MANAGEMENT AND FOLLOW-UP

Case education provided? ☐ yes ☐ no ☐ unknown *if yes*, date ____/____/____ (m / d / yy)

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? Tested for HCV?
__________________	______	_____________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy If yes, date: ____/____/____ (m d y)	☐ referred to HCP ☐ yes ☐ no tested: ____/____/____ (m d y)
__________________	______	_____________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy If yes, date: ____/____/____ (m d y)	☐ referred to HCP ☐ yes ☐ no tested: ____/____/____ (m d y)
__________________	______	_____________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy If yes, date: ____/____/____ (m d y)	☐ referred to HCP ☐ yes ☐ no tested: ____/____/____ (m d y)
__________________	______	_____________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy If yes, date: ____/____/____ (m d y)	☐ referred to HCP ☐ yes ☐ no tested: ____/____/____ (m d y)
__________________	______	_____________	____/____/____ (m d y)	☐ yes ☐ no	☐ yes ☐ no ☐ yes by proxy If yes, date: ____/____/____ (m d y)	☐ referred to HCP ☐ yes ☐ no tested: ____/____/____ (m d y)

Identify other potential concerns; provide details:

recent blood/plasma donation ☐ yes ☐ no ☐ unknown

NOTES:

ADMINISTRATION

Case report sent to OHS on ____/____/____

Completed by ______________________________ Date Completed ___________ Phone ______________ Investigation sent to OHS on ____/____/____