WEST VIRGINIA Department of Health & Human Resources BUREAU FOR PUBLIC HEALTH

Acute Hepatitis A

PATIENT DEMOGRAPHICS

Name: (last, first): ____
Address (mailing): ____
Address (physical): ____
City/State/Zip: ____
Phone (home):________________ **Phone(work/cell)**:_ _____________
Alternate contact: ☐ *Parent/Guardian* ☐ *Spouse* ☐ *Other*
Name: ________________________________ *Phone:* ______________

Birth date: __ / __ / ____ **Age**: ____
Sex: ☐ Male ☐ Female ☐ Unknown
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
Race: (Mark all that apply) ☐ White ☐ Black/Afr. Amer. ☐ Native HI/Other PI ☐ Asian ☐ Am. Ind/AK Native ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ /__ /____ Investigator: _______________________ Investigator phone: __________________

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐ Laboratory ☐ Hospital ☐ Private Provider ☐ Public Health Agency ☐ Other – Specify ____________________________
Reporter Name: ____ Reporter Phone: _________________________
Earliest date reported to LHD: __ /__ /____ **Earliest date reported to State: __ /__ /____**
Primary HCP Name: _______________________________________ Primary HCP Phone: ________________________________

CLINICAL

Y N U
☐ ☐ ☐ Patient hospitalized for this illness?
If yes, hospital name: _________________________________
Patient Chart #________________ (if available)
Admin Date: ___ / ___ / _____ Discharge 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 factor, e.g., patient request
☐ Evaluation of elevated liver enzymes
☐ Follow-up testing for previous marker of viral hepatitis
☐ Blood/Organ donor screening
☐ Unknown
☐ Other, specify ______________________

Y N U
☐ ☐ ☐ Is patient pregnant? If yes, due date ___ / ___ / _____

Clinical Findings
Y N U
☐ ☐ ☐ Is patient symptomatic?
Illness Onset date: ___ /___ /_____
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Abdominal pain/right upper quadrant pain
☐ ☐ ☐ Dark Urine
☐ ☐ ☐ Clay colored stool
☐ ☐ ☐ Anorexia
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ Fever
☐ ☐ ☐ Did the patient die?
If yes, date of death? ___ / ___ / _____
☐ ☐ ☐ Did the patient die from this illness?

Diagnosis date: ___ / ___ / _____

LABORATORY (Please submit copies of ALL Labs associated with this illness to state health department)

ALT Result________ Upper Limits ______ Date: ____________
Y N U
☐ ☐ ☐ Total antibody to hepatitis A virus (total anti-HAV)
☐ ☐ ☐ IgM antibody to hepatitis A virus (IgM anti-HAV)
☐ ☐ ☐ Hepatitis B surface antigen (HBsAg)
☐ ☐ ☐ Hepatitis B 'e' antigen (HBeAg)
☐ ☐ ☐ Total antibody to hepatitis B core antigen (Total anti-HBc)
☐ ☐ ☐ IgM antibody to hepatitis B core antigen (IgM anti-HBc)
☐ ☐ ☐ HBV DNA

AST Result________ Upper Limits ______ Date:____
Y N U
☐ ☐ ☐ Antibody to hepatitis C virus (anti-HCV)
☐ ☐ ☐ anti-HVC signal to cut-off ratio
☐ ☐ ☐ Supplemental anti-HCV assay (e.g. RIBA)
☐ ☐ ☐ HCV RNA (e.g. PCR)
☐ ☐ ☐ Antibody to hepatitis D virus (anti-HDV)
☐ ☐ ☐ Antibody to hepatitis E virus (anti-HEV)

EPIDEMIOLOGIC

Case Status: ☐ Confirmed ☐ Not a Case ☐ Unknown
Diagnosis: X Hepatitis A, Acute ☐ Hepatitis B, Acute ☐ Hepatitis B, Chronic ☐ Perinatal Hepatitis B infection
☐ Hepatitis C, Acute ☐ Hepatitis C, Chronic (past or present) ☐ Hepatitis Delta ☐ Hepatitis E, Acute

INFECTION TIMELINE

Instructions: Enter onset date in gray box. Count backward to determine probable exposure period

	Exposure period		Onset date
Days from onset	**-50** ***(Max Incubation)***	**-14** ***(Min Incubation)***	⇩
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

HEPATITIS A EXPOSURES (based on the above exposure period, unless otherwise specified)

DURING THE **2 TO 6 WEEKS** PRIOR TO ONSET OF SYMPTOMS DID/WAS THE PATIENT:

Y N U

☐ ☐ ☐ A contact of a person with confirmed Hepatitis A virus infection? If yes, type of contact
- ☐ Babysitter of this patient
- ☐ Child cared for by this patient
- ☐ Household member (non-sexual)
- ☐ Playmate
- ☐ Other (Specify) :_______________________________

☐ ☐ ☐ A child or employee in a daycare center, nursery, or preschool?
☐ ☐ ☐ A household contact of a child or employee in a daycare center nursery, or preschool?
☐ ☐ ☐ If yes for either of these, was there an identified Hepatitis A case in the child care facility?
☐ ☐ ☐ Incarcerated? If yes, when? ____________
☐ ☐ ☐ In a treatment facility or other institutional setting?
☐ ☐ ☐ In a homeless shelter or other type of shelter?
☐ ☐ ☐ If yes for any of these, was there an identified Hepatitis A case in the facility?

ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER:

How many male sex partners did patient have
☐0 ☐1 ☐2 – 5 ☐>5 ☐Unknown

How many female sex partners did patient have
☐0 ☐1 ☐2 – 5 ☐>5 ☐Unknown

Y N U

☐ ☐ ☐ Inject street drugs
☐ ☐ ☐ Use street drugs but not inject
☐ ☐ ☐ Share drugs with a partner
☐ ☐ ☐ Homeless or transient
☐ ☐ ☐ Travel outside the U.S.A. or Canada?
If yes, where did they travel? _______________
Date of travel: ___ / ___ / _____

Y N U

☐ ☐ ☐ Did anyone in the patient's household travel outside the U.S.A. or Canada?
If yes, where did they travel? _______________
Date of travel: ___ / ___ / _____

☐ ☐ ☐ Is the patient suspected of being part of a common source outbreak? If yes, type of outbreak:
- ☐ Foodborne-associated with infected food handler
- ☐ Foodborne-NOT associated with infected food handler
- ☐ Source not identified
- ☐ Waterborne

☐ ☐ ☐ Was the patient employed as a food handler during the **TWO WEEKS** prior to the onset of symptoms or while ill?

Note: If no travel outside of the U.S.A or Canada or contact with a confirmed case of Hepatitis A is reported, a food history should be collected from the case patient for as much of the incubation period (2-6 weeks) that can be recalled.

VACCINE HISTORY

VACCINE INFORMATION:

Y N U

☐ ☐ ☐ Has the patient ever received Hepatitis A vaccine? If yes:
Number of doses: ☐ 1 ☐ 2 ☐ 3 or more
Year last shot received: ____________

☐ ☐ ☐ Has the patient ever received immune globulin?

VACCINE RECORD:

Note: Vaccine record information cannot be entered in the Investigation. Go to the patient's event tab to enter.

Dose Number	**1**	**2**	**3**
Type	☐ Twinrix (Hep A/B)) ☐ Monovalent Hep A ☐ Unknown	☐ Twinrix (Hep A/B)) ☐ Monovalent Hep A ☐ Unknown	☐ Twinrix (Hep A/B)) ☐ Monovalent Hep A ☐ Unknown
Date of dose			
Unknown date?	☐	☐	☐

PUBLIC HEALTH ISSUES/ACTIONS NOTES

Y	N	U	
☐	☐	☐	Disease/Transmission Education Provided *Date: ___/___/____
☐	☐	☐	Exclude individuals in sensitive occupations (food, HCW, child care)
☐	☐	☐	Restaurant inspection
☐	☐	☐	Child care inspection
☐	☐	☐	Testing of symptomatic contacts
☐	☐	☐	Contacts issued PEP
☐	☐	☐	Patient is lost to follow up

FOOD EXPOSURE

Please use this food exposure section when the case does not report international travel, drug use, homelessness, or report contact with a person with Hepatitis A.

DURING THE **2 TO 6 WEEKS** PRIOR TO ONSET OF SYMPTOMS DID THE CASE CONSUME ANY OF THE FOLLOWING FOODS OR DRINKS:

Y	N	U	
☐	☐	☐	Food from a salad bar? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Unpasteurized juice or cider? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Raw shellfish? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Other seafood? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Fruit smoothies? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Strawberries? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Blueberries? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Mixed berries? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Pomegranate (seeds or fruit)? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________
☐	☐	☐	Green onions/scallions? If yes, where purchased/consumed?___________________ Specify items consumed:____________________________

Please list all visited restaurants during the two to six weeks prior to onset of symptoms:
____
____

CASE AND CONTACT MANAGEMENT

Definitions:
"Contact" is generally defined as a person who has had **close contact** with a confirmed case during the two weeks before and one week after onset o symptoms and usually includes:

- Household contacts **(H)**
- Sexual contacts **(S)**
- Other ongoing close personal contact (e.g., regular babysitting) **(O)**
- Staff and children in the same child care center **(C)**
- Food handlers employed in the same establishment **(F)**

HCP = health care provider

PEP = post-exposure prophylaxis

CONTACT ROSTER: Please list all **close contacts** below. Attach additional pages if necessary.

Name	**Age**	**Relation to Case**	**Contact Type** (H,S,O,C,F) (if "O", specify)	**Phone Number**	**Referred to HCP for PEP?** (yes or no)	**PEP Received?** (yes or no)

*Data is being collected as a requirement of Threat Preparedness Grant funding.