

Hepatitis C Acute Case Report Form

Patient Demographics

Name: (last, first, middle): _____	Birth date: __ / __ / ____ Age: _____
Address (mailing): _____	Sex: ☐ Male ☐ Female ☐ Unknown
Address (physical): _____	Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
City/State/Zip: _____	Race (Mark all that apply): ☐ White ☐ Black/African American
County of Residence: _____	☐ Native Hawaiian or other Pacific Islander ☐ Other
Phone (home): _____ Phone (work/cell): _____	☐ Native American/Alaskan Native ☐ Asian ☐ Unknown

Investigation Summary

Investigation Start Date: __ / __ / ____ Investigator: _____ Investigator Phone Number: _____

Report Source/Health Care Provider (HCP)

Report Source: ☐ Laboratory ☐ Hospital ☐ Private Provider ☐ Public Health Agency ☐ Other- Specify _____

Clinical

Primary HCP Name: _____	Primary HCP Phone number: _____
Y N U	Y N U
☐ ☐ ☐ Is the Patient aware of their diagnosis? Diagnosis date: __ / __ / ____	☐ ☐ ☐ Is the Patient Symptomatic? Onset Date __ / __ / ____
☐ ☐ ☐ Was the person hospitalized for this illness?	☐ ☐ ☐ Jaundice
If yes, Hospital name _____	☐ ☐ ☐ Nausea
Patient Chart Number _____ (if available)	☐ ☐ ☐ Vomiting
Admit Date _____ Discharge Date _____	☐ ☐ ☐ Abdominal pain/right upper quadrant pain
☐ ☐ ☐ Did the patient die from this illness? If Yes, Date: __ / __ / ____	☐ ☐ ☐ Dark Urine
☐ ☐ ☐ Is this patient pregnant? If yes, due date __ / __ / ____	☐ ☐ ☐ Clay Colored Stool
☐ ☐ ☐ Is this patient an insulin dependent diabetic?	☐ ☐ ☐ Anorexia
☐ Symptoms of acute hepatitis	☐ ☐ ☐ Malaise
☐ Screening of asymptomatic patient with reported risk factors	☐ ☐ ☐ Headache
☐ Evaluation of elevated liver enzymes	☐ ☐ ☐ Fever
☐ Follow-up testing for a previous marker of viral hepatitis	☐ ☐ ☐ Negative Hepatitis B testing within 6 months?
☐ Blood/Organ donor screening	If yes, Date __ / __ / ____
☐ Prenatal Screening	☐ ☐ ☐ Negative Hepatitis C testing within 12 months?
☐ Other, please specify _____	If yes, Date __ / __ / ____

Laboratory results

ALT Result: _____ Upper Limit: _____ Date: __ / __ / ____ AST Result: _____ Upper Limit: _____ Date: __ / __ / ____

Bilirubin result: _____ Upper Limit: _____ Date: __ / __ / ____

(+) (-) NA

- ☐ ☐ ☐ 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
- ☐ ☐ ☐ HEV antibody

(+) (-) NA

- ☐ ☐ ☐ Antibody to hepatitis C virus (anti-HCV)
- ☐ ☐ ☐ HCV RNA (Quantitative or Qualitative PCR)
- ☐ ☐ ☐ HCV Genotype
- ☐ ☐ ☐ HCV Antigen
- ☐ ☐ ☐ Antibody to hepatitis D virus (anti-HDV)
- ☐ ☐ ☐ HDV RNA (Quantitative or Qualitative PCR)
- ☐ ☐ ☐ Antibody to hepatitis E virus (anti-HEV)
- ☐ ☐ ☐ HEV RNA

Contact with a Case
Y N U
☐ ☐ ☐ Was the patient a contact of a confirmed or suspect case of Hepatitis C?

Type of contact: _____

Other Risk Factors
Y N U
☐ ☐ ☐ Is the patient homeless?

☐ ☐ ☐ Was the case born in the United States?

If not, what country? _____

Sexual Exposures

Ask the following questions *regardless* of patient's gender:

What is the sexual preference of the patient? _____

How many Male sex partners has the patient had? _____

How many Female sex partners has the patient had? _____

Y N U
☐ ☐ ☐ Was the patient ever treated for a sexually transmitted disease

If yes, when was the most recent treatment? _____

If yes, fill out the **Exposure Details field**
Blood Exposures
Y N U
☐ ☐ ☐ Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Was the patient employed in a medical or dental field involving direct contact with human blood?

If yes, frequency of direct blood contact:

☐ Frequent (several times a week) ☐ Infrequent

☐ ☐ ☐ Was the patient employed as a public safety worker (EMS, law enforcement, or correctional officer) having direct contact with human blood?

☐ ☐ ☐ Did the patient have any other exposure to someone else's blood? Specify _____

If yes, fill out the **Exposure Details field**
Health Care Exposures
Y N U
☐ ☐ ☐ Did the patient receive any IV transfusions and/or injections in an outpatient setting?

If yes, fill out **Exposure Details field**
☐ ☐ ☐ Did the patient receive blood products?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Did the patient undergo Hemodialysis?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Did the patient have dental work or dental surgery?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Did the patient have surgery (other than oral surgery)?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Was the patient hospitalized?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Was the patient a resident of a long term care facility?

If yes, fill out the **Exposure details field**
☐ ☐ ☐ Did the patient receive any in-home health care treatment?

If yes, fill out the **Exposure Details field**
Incarceration History
Y N U
☐ ☐ ☐ Was the patient incarcerated for more than 24 hours?

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Was the patient ever incarcerated for longer than 6 months ?

If yes, Year of most recent incarceration _____

Length of most recent incarceration _____

Tattoo, Drug Use, and Piercings
Y N U
☐ ☐ ☐ Did the patient receive a tattoo

If yes, where was the tattooing performed (check all that apply)

☐ Commercial shop ☐ Correctional Facility ☐ Other ☐ Unknown

If yes, fill out the **Exposure Details field**
☐ ☐ ☐ Did the patient inject drugs not prescribed by a doctor?

☐ ☐ ☐ Did the patient use street drugs but did not inject?

☐ ☐ ☐ Did the patient have any parts of their body pierced (other than the ear)?

If yes, where was the piercing performed? (check all that apply)

☐ Commercial Shop ☐ Correctional Facility ☐ Other ☐ Unknown

If yes, fill out **Exposure Details field**
Vaccination History
Y N U
☐ ☐ ☐ Did the patient ever receive the hepatitis B vaccine?

If yes, how many doses? _____

Manufacturer _____

Dates administered ____/____/____ and ____/____/____ and ____/____/____

☐ ☐ ☐ Was the patient tested for antibody to HBsAG within 1-2 months of the last dose?

If yes, was the resulting test ≥ 10 IU/mL? _____

☐ ☐ ☐ Did the patient ever receive the hepatitis A vaccine?

If yes, how many doses? _____

Manufacturer _____

Dates administered ____/____/____ and ____/____/____ and ____/____/____

Hepatitis Exposure Details

Exposure detail 1

Date of event/exposure: _____

Facility and Provider name where event/exposure event occurred:

Address: _____

City: _____ State: _____

Facility Phone Number: _____

Exposure detail 3
1. Exposure detail 3 2. Exposure detail 3 3. Exposure detail 3 4. Exposure detail 3 5. Exposure detail 3 6. Exposure detail 3 7. Exposure detail 3 8. Exposure detail 3 9. Exposure detail 3 10. Exposure detail 3 11. Exposure detail 3 12. Exposure detail 3 13. Exposure detail 3 14. Exposure detail 3 15. Exposure detail 3 16. Exposure detail 3 17. Exposure detail 3 18. Exposure detail 3 19. Exposure detail 3 20. Exposure detail 3 21. Exposure detail 3 22. Exposure detail 3 23. Exposure detail 3 24. Exposure detail 3 25. Exposure detail 3 26. Exposure detail 3 27. Exposure detail 3 28. Exposure detail 3 29. Exposure detail 3 30. Exposure detail 3 31. Exposure detail 3 32. Exposure detail 3 33. Exposure detail 3 34. Exposure detail 3 35. Exposure detail 3 36. Exposure detail 3 37. Exposure detail 3 38. Exposure detail 3 39. Exposure detail 3 40. Exposure detail 3 41. Exposure detail 3 42. Exposure detail 3 43. Exposure detail 3 44. Exposure detail 3 45. Exposure detail 3 46. Exposure detail 3 47. Exposure detail 3 48. Exposure detail 3 49. Exposure detail 3 50. Exposure detail 3 51. Exposure detail 3 52. Exposure detail 3 53. Exposure detail 3 54. Exposure detail 3 55. Exposure detail 3 56. Exposure detail 3 57. Exposure detail 3 58. Exposure detail 3 59. Exposure detail 3 60. Exposure detail 3 61. Exposure detail 3 62. Exposure detail 3 63. Exposure detail 3 64. Exposure detail 3 65. Exposure detail 3 66. Exposure detail 3 67. Exposure detail 3 68. Exposure detail 3 69. Exposure detail 3 70. Exposure detail 3 71. Exposure detail 3 72. Exposure detail 3 73. Exposure detail 3 74. Exposure detail 3 75. Exposure detail 3 76. Exposure detail 3 77. Exposure detail 3 78. Exposure detail 3 79. Exposure detail 3 80. Exposure detail 3 81. Exposure detail 3 82. Exposure detail 3 83. Exposure detail 3 84. Exposure detail 3 85. Exposure detail 3 86. Exposure detail 3 87. Exposure detail 3 88. Exposure detail 3 89. Exposure detail 3 90. Exposure detail 3 91. Exposure detail 3 92. Exposure detail 3 93. Exposure detail 3 94. Exposure detail 3 95. Exposure detail 3 96. Exposure detail 3 97. Exposure detail 3 98. Exposure detail 3 99. Exposure detail 3 100. Exposure detail 3

Date of event/exposure: _____

Facility and Provider name where event/exposure event occurred:

Address: _____

City: _____ State: _____

Facility Phone Number: _____

Exposure detail 2

Date of event/exposure: _____

Facility and Provider name where event/exposure event occurred:

Address: _____

City: _____ State: _____

Facility Phone Number: _____

Exposure detail 4

Date of event/exposure: _____

Facility and Provider name where event/exposure event occurred:

Address: _____

City: _____ State: _____

Facility Phone Number: _____

Public Health Issues/Actions

Y N U

- ☐ ☐ ☐ Patient has undergone a healthcare procedure and has no other risk factors?

- ☐ ☐ ☐ Investigate as a possible healthcare associated infection?

- ☐ ☐ ☐ Is the patient part of a confirmed outbreak?

If yes outbreak number

- ☐ ☐ ☐ Is the patient lost to follow up?

- ☐ ☐ ☐ Was disease education and prevention information provided to the patient? If yes, date: / /

- ☐ ☐ ☐ Was the patient aware they had viral hepatitis prior to testing?

Public Health Issues/Actions Continued

Y N U

- ☐ ☐ ☐ Does the patient have a provider for viral hepatitis?

Facility/provider name: _____

Address: _____

City: _____ State: _____ Phone number: _____

- ☐ ☐ ☐ Has the patient received medication for Viral hepatitis B?

- ☐ ☐ ☐ Was the patient referred to a provider for follow up viral hepatitis care or testing?

Facility/Provider Name: _____

Address: _____

City: _____ State: _____

Phone Number: _____

Comments: