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

# Perinatal Hepatitis C Infection

## PATIENT DEMOGRAPHICS

**Name**: (last, first, middle): ____________________________________________
**Address** (mailing): __________________________________________________
**Address** (physical): __________________________________________________
**City/State/Zip**: _____________________________________________________
**County of Residence**: _________________________________________________
**Phone** (home): ____________________ **Phone** (work/cell): ______________
**Legal Guardian's Name** (last, first): ____________________________________
**Child's relationship to Legal Guardian**: __________________________________
**Date Legal Guardianship was determined** (MM/DD/YYYY): ____/____/_______

**Birth Date** (MM/DD/YYYY): ____/____/_______
**Age**: _____
**Sex**: ☐ Male ☐ Female ☐ Unknown
**Ethnicity**: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown
**Race**: (Mark all that apply) ☐ White ☐ Black/African American ☐ Native Hawaiian/ Pacific Islander ☐ American Indian/Alaskan Native ☐ Asian ☐ Unknown ☐ Other

## INVESTIGATION SUMMARY

**Investigation Start Date:** ____/____/_______ **Investigator:** ______________________________ **Investigator Phone:** _________________________

## REPORT SOURCE/HEALTH CARE PROVIDER (HCP)

Report Source: ☐ Laboratory ☐ Hospital ☐ Private Provider ☐ Public Health Agency ☐ Other – Specify ______________________________
Reporter Name: __________________________________________________ Reporter Phone: ______________________________________
**Earliest date reported to Local Health Department:** ____/____/_______ **Earliest date reported to State:** ____/____/_______

## CLINICAL

**Primary HCP Name:** ______________________________________ **Primary HCP Phone:** ____________________________________

**Y N U**
☐ ☐ ☐ Is the child's Legal Guardian aware of the hepatitis C diagnosis?
Diagnosis Date: ____/____/_______
☐ ☐ ☐ Was the patient hospitalized for this illness?
If yes, hospital name: ________________________________
Patient Chart #___________________________ (if available)
Admit Date: ____/____/_______Discharge Date: ____/____/_______
☐ ☐ ☐ Did the patient die from this illness? **If yes, Date:** ____/____/_______

**Reason for testing:** (*check all that apply*)
☐ Symptoms of acute hepatitis
☐ Screening of an asymptomatic patient with perinatal exposure
☐ Screening of an asymptomatic patient with no risk factors
☐ Evaluation of elevated liver enzymes
☐ Follow-up testing for a previous marker of viral hepatitis
☐ Blood/Organ donor screening
☐ Other, please specify ______________________

**Clinical Findings:**
**Y N U**
☐ ☐ ☐ Is the patient symptomatic? (Check all that apply)

**Illness Onset Date:** ____/____/_______
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Abdominal pain/right upper quadrant pain
☐ ☐ ☐ Dark Urine
☐ ☐ ☐ Clay colored stool
☐ ☐ ☐ Anorexia
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ Fever

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

ALT Result________ Upper Limits _______ Date: ____/____/_______ AST Result________ Upper Limits ______ 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

**(+) (-) 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)
☐ ☐ ☐ Antibody to hepatitis E virus (anti-HEV)

Comments: ______________________________________________________________________

## EPIDEMIOLOGIC INFORMATION

**Case Status**: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case ☐ Unknown

**Diagnosis:** ☐ Perinatal Hepatitis C Infection

## PERINATAL HEPATITIS C INFECTION ADDITIONAL INFORMATION

**PERINATAL HEPATITIS C, CHILD'S BIRTH MOTHER INFORMATION:**

Birth Mother's First Name: __________________________
Birth Mother's Last Name: __________________________
Birth Mother's Date of Birth (MM/DD/YYYY): ____/____/_______

Race of Birth Mother Race, Mark all the Apply:
☐ White ☐ Black/African American
☐ Native Hawaiian/ Pacific Islander
☐ American Indian/Alaskan Native
☐ Asian ☐ Unknown

Ethnicity of Birth Mother:
☐ Hispanic or Latino
☐ Not Hispanic or Latino ☐ Unknown

Y N U
☐ ☐ ☐ Has the Birth Mother ever been test for hepatitis C?
☐ ☐ ☐ Was the Birth Mother confirmed HBsAg positive prior to/at the time of delivery?
☐ ☐ ☐ Does the Birth Mother have a regular healthcare provider?
☐ ☐ ☐ Was the Birth Mother born outside of the US?
☐ ☐ ☐ Is the child currently living with the Birth Mother?
☐ ☐ ☐ Has the child ever been in Foster Care?
Indicate Trimester of the First Prenatal Visit: ______

**CHILD'S VACCINATION HISTORY**:

Y N U
☐ ☐ ☐ Did the patient receive hepatitis B immune globulin (HBIG)?
☐ ☐ ☐ Did the patient ever receive the hepatitis B vaccine?
**If yes**, how many doses? ________
What year was the last vaccine received? ________

**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**, please complete **Exposure Details Field**

☐ ☐ ☐ Did the patient have any other exposure to someone else's blood?
Specify other: ________________________________
**If yes**, please complete **Exposure Details Field**

**Exposure Details**:

**PUBLIC HEALTH ISSUES AND ACTIONS:**

Y N U
☐ ☐ ☐ Patient has undergone a health care procedure and has ***no other risk factors***?
☐ ☐ ☐ Investigate as a possible health care-associated infection?
☐ ☐ ☐ Is the patient part of a confirmed outbreak?
**If yes**, specify outbreak number: _________
☐ ☐ ☐ Is the patient lost to follow-up?
☐ ☐ ☐ Was disease education and prevention information provided to the patient?
**If yes**, indicate date ____/____/_______

**LINKAGE TO CARE:**

Y N U
☐ ☐ ☐ Was the patient referred to a provider for follow up hepatitis care and/or testing?
If yes, Date Referred: ____/____/_______
Healthcare provider appointment date: ____/____/_______
Facility/Provider name? __________________________
Address: ________________________________________
City: __________________________ State: __________
Facility Phone #: ________________________________