

Acute/Chronic Hepatitis B or Hepatitis C

PATIENT DEMOGRAPHICS

Name: (last, first, middle): _____
 Address (mailing): _____
 Address (physical): _____
 City/State/Zip: _____
 County of Residence: _____
 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: White Black/African American
 (Mark all that apply) Native Hawaiian/ Pacific Islander
 American Indian/Alaskan Native
 Asian Unknown

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 patient aware of their 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 reported risk factors
 Screening of an asymptomatic patient with no risk factors (e.g. patient request)
 Evaluation of elevated liver enzymes
 Follow-up testing for a previous marker of viral hepatitis
 Blood/Organ donor screening
 Prenatal Screening
 Other, please specify _____

Y N U

Is the patient pregnant? **If yes, Due Date:** __/__/____

Is the patient an insulin dependent diabetic?

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

Evidence of Seroconversion:

Y N U

Negative Hepatitis B testing *within 6 months?*
If yes, Date: __/__/____

Negative Hepatitis C testing *within 12 months?*
If yes, Date: __/__/____

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)

EPIDEMIOLOGIC

Case Status: Confirmed Probable Suspect Not a Case Unknown

Diagnosis: Hepatitis B, Acute Hepatitis B, Chronic
 Hepatitis C, Acute Hepatitis C, Chronic (past or present)

Complete this page for acute cases of hepatitis B or hepatitis C only.

The time period of interest differs for acute hepatitis B and hepatitis C. For hepatitis B, the incubation period is 6 weeks – 6 months prior to onset of symptoms. For hepatitis C, the incubation period is 2 weeks – 6 months prior to onset of symptoms.

ACUTE HEPATITIS B OR HEPATITIS C EXPOSURES WITHIN SIX MONTHS OF SYMPTOM ONSET

CONTACT WITH A CASE:

Y N U

Was the patient a contact of a confirmed or suspect case of hepatitis B or hepatitis C?

Type of contact: _____

If other, please specify : _____

SEXUAL EXPOSURES:

Ask both questions **REGARDLESS** of the patient's gender:

What is the sexual preference of the patient? _____

How many Male sex partners did the patient have?

0 1 2-5 >5 Unknown

How many Female sex partners did the patient have?

0 1 2-5 >5 Unknown

Y N U

Was the patient ever treated for a sexually-transmitted disease?

If yes, in what year was the most recent treatment? _____

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 Fields**.

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 weekly) Infrequent

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

If yes, frequency of direct blood contact:

Frequent (several times weekly) Infrequent

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

If yes, please complete **Exposure Details Fields**.

TATTOOING, 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, please provide details in the **Exposure Details Fields**.

Y N U

Did the patient inject drugs not prescribed by a doctor?

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

TATTOOING, DRUG USE, AND PIERCINGS CONTINUED:

Y N U

Did the patient have any part 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, please complete the **Exposure Details Fields**.

HEALTH CARE EXPOSURES:

Y N U

Did the patient receive any IV infusions and/or injections in an outpatient setting?

If yes, please complete **Exposure Details Fields**.

Did the patient receive blood or blood products (transfusion)? If yes, please complete **Exposure Details Fields**.

Did the patient undergo hemodialysis? If yes, please complete **Exposure Details Fields**.

Did the patient have dental work or oral surgery? If yes, please complete **Exposure Details Fields**.

Did the patient have surgery? (other than oral surgery) If yes, please complete **Exposure Details Fields**.

Was the patient hospitalized? If yes, please complete **Exposure Details Fields**.

Was the patient a resident of a long term care facility? If yes, please complete **Exposure Details Fields**.

Did the patient receive any in-home health care treatment? If yes, please complete **Exposure Details Fields**.

INCARCERATION HISTORY:

Y N U

Was the patient incarcerated for more than 24 hours? If yes, please complete **Exposure Details Fields**.

Was the patient ever incarcerated for longer than 6 months? Year of most recent incarceration _____ Length of most recent incarceration _____

VACCINATION HISTORY:

Y N U

Did the patient ever receive the hepatitis B vaccine? If yes, how many doses? _____ In what year was the last shot received? _____

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

Was the serum anti-HBs >=10 IU/ml? (answer 'Yes' if lab result reported was positive or reactive)

Complete the chronic risk factor questions for chronic cases of hepatitis B or hepatitis C only.

- A case is considered to be chronically infected with hepatitis B if infected 6 months or longer.
- A case is considered to be chronically infected with hepatitis C if infected 12 months or longer.

CHRONIC HEPATITIS B OR HEPATITIS C RISK FACTORS **ACUTE AND CHRONIC HEPATITIS B OR HEPATITIS C**

CHRONIC HEPATITIS C INFECTION ONLY:

Y N U

- Did the patient receive a blood transfusion prior to 1992?
- Did the patient receive an organ transplant prior to 1992?

RISK FACTORS FOR CHRONIC HEPATITIS B AND C:

Y N U

- Did the patient receive clotting factor concentrates prior to 1987?
- Was the patient ever on long-term hemodialysis?
- Has the patient ever injected drugs not prescribed by a doctor?
- Did the patient ever use street drugs but did not inject?

How many sex partners has the patient had (lifetime)? _____

Y N U

- Was the patient ever incarcerated?
- Was the patient ever treated for a sexually transmitted disease?
- Was the patient ever a contact of a person who had viral hepatitis?
Type of contact: _____
If other specify : _____
- Was the patient ever employed in a medical or dental field involving direct contact with human blood?
- Does the patient have a provider of care for hepatitis?
If yes, specify : _____
- Has the patient received medication for this illness?

What is the birth county of the patient's mother? _____

PUBLIC HEALTH ISSUES/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 ___/___/___.

ACUTE AND CHRONIC HEPATITIS B OR HEPATITIS C EXPOSURE DETAILS

Exposure Detail 1

If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred _____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 2

If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred _____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 3

If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred _____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 4

If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred _____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 5

If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred _____
City: _____ State: _____
Facility phone #: _____

Exposure Detail 6

If yes to: _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred _____
City: _____ State: _____
Facility phone #: _____