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

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: (Mark all that apply) ☐White ☐Black/African American ☐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: ___________
(+) (-) 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

AST Result________ Upper Limits ______ Date: ___________
(+) (-) 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)

Y = Yes N=No (+) =Positive (-) = Negative U = Unknown NA=Not applicable

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 lU/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

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 country of the patient's mother? _______________________

ACUTE AND CHRONIC HEPATITS B OR HEPATITIS C

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 __/__/____.

LINKAGE TO CARE:

Y N U
☐ ☐ ☐ Was the patient aware they had hepatitis prior to lab testing?
☐ ☐ ☐ Does the patient have a provider for hepatitis?
Facility/Provider name? _________________________
Address: ______________________________________
City: _________________________ State: __________
Facility phone #: _______________________________

Y N U
☐ ☐ ☐ Has the patient received medication for the type of hepatitis being reported?
☐ ☐ ☐ 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 #: _______________________________

ACUTE AND CHRONIC HEPATITS 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 #: _______________________________