

Hepatitis D Acute Case Report Form

Patient Demographics

Name: (last, first, middle): _____
 Address (mailing): _____
 Address (physical): _____
 City/State/Zip: _____
 County of Residence: _____

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 or other Pacific Islander ☐ Other

☐ 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: _____

Y N U

☐ ☐ ☐ Is the Patient aware of their diagnosis? Diagnosis date: __ / __ / __

☐ ☐ ☐ Was the person hospitalized for this illness?

If yes, Hospital name _____

Patient Chart Number _____ (if available)

Admit Date _____ Discharge Date _____

☐ ☐ ☐ Did the patient die from this illness? If Yes, Date: __ / __ / __

☐ ☐ ☐ Is this patient pregnant? If yes, due date __ / __ / __

☐ ☐ ☐ Is this patient an insulin dependent diabetic?

☐ Symptoms of acute hepatitis

☐ Screening of asymptomatic patient with reported risk factors

☐ Evaluation of elevated liver enzymes

☐ Follow-up testing for a previous marker of viral hepatitis

☐ Blood/Organ donor screening

☐ Prenatal Screening

☐ Other, please specify _____

Primary HCP Phone number: _____

Y N U

☐ ☐ ☐ Is the Patient Symptomatic? Onset Date __ / __ / __

☐ ☐ ☐ Jaundice

☐ ☐ ☐ Nausea

☐ ☐ ☐ Vomiting

☐ ☐ ☐ Abdominal pain/right upper quadrant pain

☐ ☐ ☐ Dark Urine

☐ ☐ ☐ Clay Colored Stool

☐ ☐ ☐ Anorexia

☐ ☐ ☐ Malaise

☐ ☐ ☐ Headache

☐ ☐ ☐ Fever

☐ ☐ ☐ Negative Hepatitis B testing within 6 months?

If yes, Date __ / __ / __

☐ ☐ ☐ Negative Hepatitis C testing within 12 months?

If yes, Date __ / __ / __

Laboratory results

ALT Result: _____ Upper Limit: _____ Date: __ / __ / __ AST 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 D?

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 Type	Frequency	Duration (Months)	Location	Associated Risk Factors	Current Status	Notes	Referral Status	Referral Date	Referral Location
Sexual Contact	Regular	12	Local	Unprotected	Active				
Needle Use	Occasional	6	Overseas	Shared	Resolved				
Blood Exposure	One-time	3	Local	Accidental	Resolved				
Other	None	0	None	None	None				

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: