West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH

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: _____

Primary HCP Phone number: _____

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 _____

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

Hepatitis D Exposure Please note that these questions apply within the 6 months prior to symptom onset

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 detail 1

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 3

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:

_____

_____

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