

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES PUBLIC HEALTH SERVICE

VIRAL HEPATITIS CASE REPORT

CDC Centers for Disease Control and Prevention Hepatitis Branch, (G37) Atlanta, Georgia 30333

The following questions should be asked for every case of viral hepatitis

Prefix: (Mr. Mrs. Miss Ms. etc) Last: First: Middle: Preferred Name (nickname): Maiden: Address: Street: City: Phone: Zip Code: SSN # (optional) Only data from lower portion of form will be transmitted to CDC State: County: Date of Public Health Report Was this record submitted to CDC through the NETSS system? If yes, please enter NETSS ID NO. If no, please enter STATE CASE NO.

DEMOGRAPHIC INFORMATION

RACE (check all that apply): Amer Indian or Alaska Native, Black or African American, White, Asian, Native Hawaiian or Pacific Islander, Other Race, specify: ETHNICITY: Hispanic, Non-hispanic, Other/Unknown SEX: Male, Female, Unk PLACE OF BIRTH: USA, Other DATE OF BIRTH: AGE: (00= <1yr, 99= Unk)

CLINICAL & DIAGNOSTIC DATA

REASON FOR TESTING: (Check all that apply) Symptoms of acute hepatitis, Evaluation of elevated liver enzymes, Screening of asymptomatic patient with reported risk factors, Blood / organ donor screening, Screening of asymptomatic patient with no risk factors (e.g., patient requested), Follow-up testing for previous marker of viral hepatitis, Prenatal screening, Unknown, Other: specify:

CLINICAL DATA: Diagnosis date, Is patient symptomatic?, Was the patient Jaundiced?, Hospitalized for hepatitis?, Was the patient pregnant?, Did the patient die from hepatitis? LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS: ALT [SGPT] Result, AST [SGOT] Result, Date of ALT result, Date of AST result DIAGNOSTIC TESTS: CHECK ALL THAT APPLY: Total antibody to hepatitis A virus, IgM antibody to hepatitis A virus, Hepatitis B surface antigen [HBsAg], Total antibody to hepatitis B core antigen [total anti-HBc], IgM antibody to hepatitis B core antigen [IgM anti-HBc], Antibody to hepatitis C virus [anti-HCV], Supplemental anti-HCV assay [e.g., RIBA], HCV RNA [e.g., PCR], Antibody to hepatitis D virus [anti-HDV], Antibody to hepatitis E virus [anti-HEV]

DIAGNOSIS: (Check all that apply) Acute hepatitis A, Acute hepatitis B, Acute hepatitis C, Acute hepatitis E, Chronic HBV infection, HCV infection (chronic or resolved), Acute non-ABCD hepatitis, Perinatal HBV infection, Hepatitis Delta (co- or super-infection)

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Patient History- Acute Hepatitis A

NETSS ID NO.

STATE CASE NO. _____

During the 2-6 weeks prior to onset of symptoms-				Yes	No	Unk		
Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, was the contact (check one)								
• household member (non-sexual)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• sex partner				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• child cared for by this patient				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• babysitter of this patient				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• playmate				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• other _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Was the patient								
• a child or employee in a day care center, nursery, or preschool ?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• a household contact of a child or employee in a day care center, nursery or preschool ?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes for either of these, was there an identified hepatitis A case in the child care facility?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Please ask both of the following questions regardless of the patient's gender.								
In the 2- 6 weeks before symptom onset how many				0	1	2-5	>5	Unk
• male sex partners did the patient have?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• female sex partners did the patient have?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the 2- 6 weeks before symptom onset				Yes	No	Unk		
Did the patient inject drugs not prescribed by a doctor?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the patient use street drugs but not inject?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the patient travel outside of the U.S.A. or Canada				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• If yes, where? 1) _____ 2) _____								
(Country) 3) _____								
In the 3 months prior to symptom onset								
Did anyone in the patient's household travel outside of the U.S. A. or Canada?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• If yes, where? 1) _____ 2) _____								
(Country) 3) _____								
Is the patient suspected as being part of a common-source outbreak?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, was the outbreak								
Foodborne- associated with an infected food handler				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Foodborne - NOT associated with an infected food handler				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• specify food item _____								
Waterborne				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Source not identified				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Was the patient employed as a food handler during the TWO WEEKS prior to onset of symptoms or while ill?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

VACCINATION HISTORY			
Yes No Unk			
Has the patient ever received the hepatitis A vaccine ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
• If yes, how many doses?			
1 ≥ 2			
<input type="checkbox"/> <input type="checkbox"/>			
• In what year was the last dose received?			
<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>			
Yes No Unk			
Has the patient ever received immune globulin ?			
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
• If yes, when was the last dose received?			
_____ / _____			
mo yr			

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Perinatal Hepatitis B Virus Infection

NETSS ID NO.

STATE CASE NO. _____

RACE OF MOTHER:

- Amer Ind or Alaska Native Black or African American White Unknown
 Asian Native Hawaiian or Pacific Islander Other Race, specify: _____

ETHNICITY OF MOTHER:

- Hispanic
Non-hispanic
Other/Unknown

Was **Mother** born outside of United States? Yes No Unk If yes, what country? _____

Was the **Mother** confirmed HBsAg positive prior to or at time of delivery ? ... Yes No Unk

• If no, was the mother confirmed HBsAg positive after delivery? Yes No Unk

Date of HBsAg positive test result MM/DD/YYYY

How many doses of hepatitis B vaccine did the child receive ? 0 1 2 3

• When?

• Dose 1- MM/DD/YYYY

• Dose 2- MM/DD/YYYY

• Dose 3- MM/DD/YYYY

Yes No Unk

Did the child receive hepatitis B immune globulin (HBIG)? Yes No Unk

• If yes, on what date did the child receive HBIG? MM/DD/YYYY

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NETSS ID NO.

STATE CASE NO. _____

Patient History- Acute Hepatitis C

<p>During the 2 weeks- 6 months prior to onset of symptoms was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection? Yes No Unk</p> <p>If yes, type of contact</p> <ul style="list-style-type: none"> • Sexual <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Household [Non-sexual] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 	<p>Ask both of the following questions regardless of the patient's gender.</p> <p>In the 6 months before symptom onset how many 0 1 2-5 >5 Unk</p> <ul style="list-style-type: none"> • male sex partners did the patient have? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • female sex partners did the patient have? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <p>Was the patient EVER treated for a sexually transmitted disease? Yes No Unk</p> <ul style="list-style-type: none"> • If yes, in what year was the most recent treatment? <u> Y Y Y Y </u> <p>During the 2 weeks- 6 months prior to onset of symptoms</p> <ul style="list-style-type: none"> • inject drugs not prescribed by a doctor? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • use street drugs but not inject? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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<p>During the 2 weeks- 6 months prior to onset of symptoms</p> <p>Did the patient- Yes No Unk</p> <ul style="list-style-type: none"> • undergo hemodialysis? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • have an accidental stick or puncture with a needle or other object contaminated with blood? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • receive blood or blood products [transfusion] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">• if yes, when? <u> MM/DD/YYYY </u> • receive any IV infusions and/or injections in the outpatient setting... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • have other exposure to someone else's blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">specify: _____ <p>During the 2 weeks - 6 months prior to onset of symptoms</p> <ul style="list-style-type: none"> • Was the patient employed in a medical or dental field involving direct contact with human blood? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">If yes, frequency of direct blood contact? <li style="padding-left: 40px;">Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/> • Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">If yes, frequency of direct blood contact? <li style="padding-left: 40px;">Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/> • Did the patient receive a tattoo? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">where was the tattooing performed? (select all that apply) <li style="padding-left: 40px;"><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____ <li style="padding-left: 40px;">parlor / shop facility 	<p>During the 2 weeks- 6 months prior to onset of symptoms</p> <ul style="list-style-type: none"> • Did the patient have any part of their body pierced (other than ear)? <li style="padding-left: 20px;">where was the piercing performed? (select all that apply) <li style="padding-left: 40px;"><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____ <li style="padding-left: 40px;">parlor / shop facility <li style="padding-left: 20px;">Yes No Unk • Did the patient have dental work or oral surgery? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Did the patient have surgery? (other than oral surgery) .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Was the patient- Check all that apply <li style="padding-left: 20px;">• hospitalized? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">• a resident of a long term care facility? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">• incarcerated for longer than 24 hours? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 40px;">if yes, what type of facility (check all that apply) <li style="padding-left: 60px;">prison <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 60px;">jail <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 60px;">juvenile facility <input type="checkbox"/> <input type="checkbox"/> <hr style="border-top: 1px dashed black;"/> <p>During his/her lifetime, was the patient EVER</p> <ul style="list-style-type: none"> • incarcerated for longer than 6 months? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • If yes, <li style="padding-left: 20px;">what year was the most recent incarceration? <u> Y Y Y Y </u> <li style="padding-left: 20px;">for how long? _ _ _ _ mos
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NETSS ID NO.

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Patient History- Hepatitis C Virus Infection (chronic or resolved)

STATE CASE NO. _____

The following questions are provided as a guide for the investigation of lifetime risk factors for HCV infection. Routine collection of risk factor information for persons who test HCV positive is not required. However, collection of risk factor information for such persons may provide useful information for the development and evaluation of programs to identify and counsel HCV-infected persons.

	Yes	No	Unk		Yes	No	Unk
• Did the patient receive a blood transfusion prior to 1992?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Was the patient ever employed in a medical or dental field involving direct contact with human blood? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did the patient receive an organ transplant prior to 1992?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Did the patient receive clotting factor concentrates produced prior to 1987?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Was the patient ever on long-term hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Has the patient ever injected drugs not prescribed by a doctor even if only once or a few times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• How many sex partners has the patient had (approximate lifetime) ? _____							
• Was the patient ever incarcerated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Was the patient ever treated for a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Was the patient ever a contact of a person who had hepatitis ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, type of contact							
• Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Household [Non-sexual]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				