Viral Hepatitis Case Report

Perinatal Hepatitis B Virus Infection

Michigan Department of Community Health

Communicable Disease Division

Investigation Information

Investigation ID	Onset Date mm/dd/yyyy	Diagnosis Date mm/dd/yyyy	Referral Date mm/dd/yyyy	Case Entry Date mm/dd/yyyy	Case Completion Date mm/dd/yyyy

Investigation Status	Case Status
	○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Status	Patient Status Date mm/dd/yyyy	Part of an outbreak?	Outbreak Name	Case Updated Date mm/dd/yyyy

Patient Information

Patient ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex	Date of Birth mm/dd/yyyy	Age	Age Units
○ *Male* ○ *Female* ○ *Unknown*			○ *Days* ○ *Months* ○ *Years*

Race
(Check all that apply)

☐ *Caucasian* ☐ *African American* ☐ *American Indian/Alaska Native* ☐ *Hawaiian/Pacific Islander*
☐ *Asian* ☐ *Unknown* ☐ *Other (Specify)*_____

Hispanic Ethnicity	Arab Ethnicity
○ *Hispanic/Latino* ○ *Non-Hispanic/Latino* ○ *Unknown*	○ *Arab* ○ *Non-Arab* ○ *Unknown*

Worksites/School	Occupations/Grade

Referral Information

Person Providing Referral

First	Last	Phone ###-###-####	Ext.	Email

Referral Information cont.

Primary Physician

First	Last	Phone ###-###-####	Ext.	Email

Street Address

City	County	State	Zip

Hospital Information

Patient Hospitalized	Hospital	Hospital City	Hospital Record No.
○ *Yes* ○ *No* ○ *Unknown*			

Admission Date	Discharge Date	Days Hospitalized
mm/dd/yyyy	mm/dd/yyyy	

Clinical Information and Patient History

Place of Birth:	Did the patient die from hepatitis?	If yes, specify the date of death:
○ *USA* ○ *Other*_____	○ *Yes* ○ *No* ○ *Unknown*	mm/dd/yyyy

Reason for Testing:
(Check all that apply)

- ☐ *Symptoms of acute hepatitis*
- ☐ *Screening of asymptomatic patient with reported risk factors*
- ☐ *Screening of asymptomatic patient with no risk factors (e.g., patient requested)*
- ☐ *Prenatal screening*
- ☐ *Other*_____
- ☐ *Evaluation of elevated liver enzymes*
- ☐ *Blood / Organ donor screening*
- ☐ *Follow-up testing for previous marker of viral hepatitis*
- ☐ *Unknown*

Is the patient symptomatic?	Is or was the patient jaundiced?	Is or was the patient pregnant?	If yes, specify the due or delivery date:
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	mm/dd/yyyy

Diagnosis:
(Check all that apply)

- ☐ *Acute hepatitis A*
- ☐ *Acute hepatitis E*
- ☐ *Acute non-ABCD hepatitis*
- ☐ *Acute hepatitis B*
- ☐ *Chronic HBV infection*
- ☐ *Perinatal HBV infection*
- ☐ *Acute hepatitis C*
- ☐ *HCV infection (chronic or resolved)*
- ☐ *Hepatitis Delta (co- or super-infection)*

Diagnostic Tests

Test Name	Result
	P=Positive N=Negative UNK=Unknown
Total antibody, hepatitis A virus [total anti-HAV]	
IgM antibody to hepatitis A virus [IgM anti-HAV]	
Hepatitis B surface antigen [HBsAg]	
Total antibody, hepatitis B core antigen [Total anti-HBc]	
IgM antibody, hepatitis B core antigen [IgM anti-HBc]	
Antibody to hepatitis D virus [anti-HDV]	
Antibody to hepatitis E virus [anti-HEV]	
Antibody to hepatitis C virus [anti-HCV]	
Supplemental anti-HCV assay [e.g., RIBA]	
HCV RNA [e.g., PCR]	

anti-HCV signal to cut-off ratio

Liver Enzyme Levels at Time of Diagnosis

Test Name	Result	Upper Limit Normal	Date of Result
			mm/dd/yyyy
ALT (SGPT)			
AST (SGOT)			

Epidemiologic Information

Race of Mother:

○ *Caucasian* ○ *African American* ○ *American Indian/Alaska Native* ○ *Hawaiian/Pacific Islander*
○ *Asian* ○ *Unknown* ○ *Other (Specify)*_____

Ethnicity of Mother:

○ *Hispanic/Latino* ○ *Non-Hispanic/Latino* ○ *Unknown*

Was Mother born outside of the United States?

○ *Yes* ○ *No* ○ *Unknown*

If yes, what Country?

Was the Mother confirmed HBsAg positive prior to or at time of delivery?

○ *Yes* ○ *No* ○ *Unknown*

If no, was the Mother confirmed HBsAg positive after delivery?

○ *Yes* ○ *No* ○ *Unknown*

Date of HBsAg positive test result:
mm/dd/yyyy

How many doses of hepatitis B vaccine did the child receive?

○ *Zero* ○ *1* ○ *2* ○ *3 or more*

Dose 1 Date
mm/dd/yyyy

Dose 2 Date
mm/dd/yyyy

Dose 3 Date
mm/dd/yyyy

Did the child receive hepatitis B immune globulin (HBIG)?

○ *Yes* ○ *No* ○ *Unknown*

If yes, on what date did the child receive HBIG?
mm/dd/yyyy

Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
mm/dd/yyyy				mm/dd/yyyy

Other Information

Local 1	Local 2

Name of Person interviewed	Relationship to patient	Date of interview mm/dd/yyyy

Submitted by:	Date mm/dd/yyyy	Health Department	Phone Number ###-###-####	Ext.

Other Information cont.

Comments or Additional Information