Viral Hepatitis Case Report

Acute Hepatitis A

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* 06/27/2014	Case Completion Date *mm/dd/yyyy*

Investigation Status: NEW

Case Status: ◯ Confirmed ◯ Not a Case ◯ Probable ◯ Suspect ◯ Unknown

Patient Status	Patient Status Date *mm/dd/yyyy* 06/27/2014	Part of an outbreak?	Outbreak Name	Case Updated Date *mm/dd/yyyy* 06/27/2014

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: ◯ Male ◯ Female ◯ Unknown

Date of Birth *mm/dd/yyyy*

Age

Age Units: ◯ Days ◯ Months ◯ Years

Race *(Check all that apply)*

☐ Caucasian ☐ African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Unknown

☐ Other (Specify)

Hispanic Ethnicity: ◯ Hispanic/Latino ◯ Non-Hispanic/Latino ◯ Unknown

Arab Ethnicity: ◯ Arab ◯ Non-Arab ◯ Unknown

Worksites/School

Occupations/Grade

Referral Information

Person Providing Referral

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

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Referral Information cont.

Primary Physician

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

Street Address

City	County	State	Zip

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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:	Was the patient aware they had viral hepatitis prior to lab testing?
◯ USA ◯ Other	◯ Yes ◯ No ◯ Unknown	*mm/dd/yyyy*	◯ Yes ◯ No ◯ Unknown

Does the patient have a provider of care for hepatitis?	Does the patient have diabetes?	Diabetes Diagnosis Date:
◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown	mm/dd/yyyy

Reason for Testing:
(Check all that apply)

- ☐ Symptoms of acute hepatitis
- ☐ 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 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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Vaccine History

Has patient ever received the hepatitis A vaccine? ◯ Yes ◯ No ◯ Unknown	If Yes, how many doses of hepatitis A vaccine did the patient receive? ◯ One Dose ◯ Two or More Doses

If Yes, what year was the last dose received? *yyyy*	Has the patient ever received immune globulin? ◯ Yes ◯ No ◯ Unknown	If Yes, when was the last dose received? *mm/yyyy*

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Diagnostic Tests

Test Name	Result	Date
	(P=Positive N=Negative UNK=Unknown)	*mm/dd/yyyy*
Hepatitis A		
Total antibody, hepatitis A virus [total anti-HAV]		
IgM antibody to hepatitis A virus [IgM anti-HAV]		
Hepatitis B		
Hepatitis B surface antigen [HBsAg]		
Total antibody, hepatitis B core antigen [Total anti-HBc]		
IgM antibody to hepatitis B core antigen [IgM anti-HBc]		
Nucleic Acid Testing for hepatitis B [HBV NAT]		
Hepatitis B Virus DNA Quantitative by PCR		
Hepatitis B virus DNA Qualitative by PCR		
Antibody to the hepatitis B surface antigen [anti-HBs]		
Hepatitis B e antigen [HBeAg]		
Antibody to hepatitis B e antigen [HBeAb or anti-HBe]		
Hepatitis B Virus Genotype		
Hepatitis B Virus Drug Resistant		
Hepatitis C		
Antibody to hepatitis C virus [anti-HCV]		
Anti-HCV signal to cut-off ratio		
Supplemental anti-HCV assay [e.g., RIBA]		
HCV RNA [e.g., PCR]		
Quantitative Hepatitis C RT-PCR		
Qualitative Hepatitis C RT-PCR		
Hepatitis C Virus Genotype		
Hepatitis D		
Antibody to hepatitis D virus [anti-HDV]		
Hepatitis E		
Antibody to hepatitis E virus [IgM anti-HEV]		
IgG hepatitis E antibody [IgG anti-HEV]		
Other		
Interleukin-28		
Biopsy		
Fibroscan		

Liver Enzyme Levels at Time of Diagnosis

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

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Epidemiologic Information

Please answer the following questions for the time period 2 - 6 weeks prior to the onset of symptoms:

Has the patient had **contact with:**

A laboratory-confirmed case of Hepatitis A?
- Yes
- No
- Unknown

A suspected case of hepatitis A?
- Yes
- No
- Unknown

If yes, was the contact a:

Household member (non-sexual)	Yes	No	Unknown
Sex partner of patient	Yes	No	Unknown
Babysitter of patient	Yes	No	Unknown
Playmate of patient	Yes	No	Unknown
Child cared for by patient	Yes	No	Unknown
Other (specify)			

Was the **patient** a:

Food Worker?	Yes	No	Unknown	If yes, where?
Care Facility (i.e. nursing, group home) Resident or Employee	Yes	No	Unknown	If yes, where?
Correction Facility Resident or Employee?	Yes	No	Unknown	If yes, where?
Daycare/Preschool Attendee or Employee?	Yes	No	Unknown	If yes, where?
Household Contact of Daycare/Preschool Attendee or Employee?	Yes	No	Unknown	Facility?

If yes for either of those last two options, was there an identified hepatitis A case in the child care facility?
Yes No Unknown

Did the patient recieve a blood transfusion in the last 6 weeks?
Yes No Unknown

What is the sexual preference of the patient?
Heterosexual Homosexual Bisexual Unknown

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

Did the patient inject drugs not prescribed by a doctor?
Yes No Unknown

Did the patient use street drugs, but not inject?
Yes No Unknown

Is the patient suspected as being part of a common-source outbreak?
Yes No Unknown

If Yes, the type of outbreak with which the patient is associated:

Foodborne - assoc. w/ an infected food handler	Yes	No	Unknown
Foodborne - NOT assoc. w/ an infected food handler	Yes	No	Unknown
Source not identified	Yes	No	Unknown
Waterborne	Yes	No	Unknown

If the outbreak is foodborne and NOT associated with an infected food handler, specify food item:

Did the patient travel outside of the U.S.A. or Canada in the two to six weeks before symptom onset?
Yes No Unknown

What was the principal reason for travel?
Business New Immigrant
Tourism Visiting relatives/friends
Adoption Other Unknown

If Yes, where?

(Country)

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Epidemiologic Information (Cont.)

Did anyone in the patient's household travel outside of the U.S.A. or Canada in the three months before symptom onset? ◯ Yes ◯ No ◯ Unknown	If Yes, where? *(Country)*

Did the patient travel within the U.S.A. (in/out state) in the 6 weeks prior to onset? ◯ Yes ◯ No ◯ Unknown	If yes, Location(s):	If yes, Date(s):

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Information on Food Consumed Outside the Home

List any other food consumed OUTSIDE the home in the 2-6 weeks prior to illness onset: (Include: Carry out, Convenience Stores, Events, Fast Food, Parties, Restaurants, Travel or Work-Related Meals)

Date	Name	Food Consumed	Location/Event
(mm/dd/yyyy)	*( )*	*( )*	*( )*

Did the person consume raw seafood?	If yes, specify type.	If yes, specify location.
◯ Yes ◯ No ◯ Unknown		

Control Measures

Check the appropriate box(es) for those control measures implemented during the public health follow-up. Multiple selections permitted. Complete the start date field using the earliest date a control measure was initiated.

Control Measures Start Date
mm/dd/yyyy

Control Measures Implemented
(Check all that apply)

- ☐ Contact tracing
- ☐ Immunization (active/passive) administered or recommended to contacts
- ☐ Decision made not to initiate Control Measures
- ☐ Other
- ☐ Education
- ☐ Recommendation for Control Measures
- ☐ Inability to initiate Control Measures despite efforts to do so

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Contact Information

List group functions, additional travel history, etc., during 14 days prior to onset:

Household Contacts

Name of Contact	Age	Sex	Relation	Prophylaxis Recommended	Prophylaxis Given	Date Prophylaxis Given
( )	*( )*	*(F=Female M=Male U=Unknown)*	*( )*	*(Y=Yes N=No UNK=Unknown)*		

Other Close or Intimate Contacts

Name of Contact	Age	Sex	Relation	Prophylaxis Recommended	Prophylaxis Given	Date Prophylaxis Given
( )	*( )*	*(F=Female M=Male U=Unknown)*	*( )*	*(Y=Yes N=No UNK=Unknown)*		

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Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
(mm/dd/yyyy)				*(mm/dd/yyyy)*

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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

Case Notes

Notes