

# Viral Hepatitis Case Report

## Hepatitis D

Michigan Department of Community Health

Communicable Disease Division

Investigation Information					
Investigation ID	Onset Date <i>mm/dd/yyyy</i>	Diagnosis Date <i>mm/dd/yyyy</i>	Referral Date <i>mm/dd/yyyy</i>	Case Entry Date <i>mm/dd/yyyy</i> 06/27/2014	Case Completion Date <i>mm/dd/yyyy</i>
Investigation Status NEW			Case Status <input type="radio"/> Confirmed <input type="radio"/> Not a Case <input type="radio"/> Probable <input type="radio"/> Suspect <input type="radio"/> Unknown		
Patient Status	Patient Status Date <i>mm/dd/yyyy</i> 06/27/2014	Part of an outbreak?	Outbreak Name	Case Updated Date <i>mm/dd/yyyy</i> 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 <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Date of Birth <i>mm/dd/yyyy</i>	Age	Age Units <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years		
Race (Check all that apply) <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)					
Hispanic Ethnicity <input type="radio"/> Hispanic/Latino <input type="radio"/> Non-Hispanic/Latino <input type="radio"/> Unknown			Arab Ethnicity <input type="radio"/> Arab <input type="radio"/> Non-Arab <input type="radio"/> Unknown		
Worksites/School			Occupations/Grade		
Referral Information					
Person Providing Referral					
First	Last	Phone ###-###-####	Ext.	Email	

Case ID

First Name

Last Name

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**Referral Information cont.**

*Primary Physician*

First	Last	Phone ###-###-####	Ext.	Email
Street Address				
City	County	State	Zip	

Case ID

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**Hospital Information**

Patient Hospitalized <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Hospital _____	Hospital City _____	Hospital Record No. _____
Admission Date mm/dd/yyyy _____	Discharge Date mm/dd/yyyy _____	Days Hospitalized _____	

**Clinical Information and Patient History**

Place of Birth: <input type="radio"/> USA <input type="radio"/> Other _____	Did the patient die from hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, specify the date of death: mm/dd/yyyy _____	Was the patient aware they had viral hepatitis prior to lab testing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Does the patient have a provider of care for hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Does the patient have diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Diabetes Diagnosis Date: mm/dd/yyyy _____	

Reason for Testing:  
(Check all that apply)

<input type="checkbox"/> Year of birth (1945-1965)	<input type="checkbox"/> Evaluation of elevated liver enzymes
<input type="checkbox"/> Symptoms of acute hepatitis	<input type="checkbox"/> Blood / Organ donor screening
<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors	<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis
<input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prenatal screening	
<input type="checkbox"/> Other _____	

Is the patient symptomatic? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is or was the patient jaundiced? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is or was the patient pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, specify the due or delivery date: mm/dd/yyyy _____
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Diagnosis:  
(Check all that apply)

<input type="checkbox"/> Acute hepatitis A	<input type="checkbox"/> Acute hepatitis B	<input type="checkbox"/> Acute hepatitis C
<input type="checkbox"/> Acute hepatitis E	<input type="checkbox"/> Chronic HBV infection	<input type="checkbox"/> HCV infection (chronic or resolved)
<input type="checkbox"/> Acute non-ABCD hepatitis	<input type="checkbox"/> Perinatal HBV infection	<input type="checkbox"/> Hepatitis Delta (co- or super-infection)

**Diagnostic Tests**

Test Name	Result	Date
	<i>(P=Positive N=Negative UNK=Unknown)</i>	<i>mm/dd/yyyy</i>

**Hepatitis A**

Total antibody, hepatitis A virus [total anti-HAV]	<input type="checkbox"/>	
IgM antibody to hepatitis A virus [IgM anti-HAV]	<input type="checkbox"/>	

**Hepatitis B**

Hepatitis B surface antigen [HBsAg]	<input type="checkbox"/>	
Total antibody, hepatitis B core antigen [Total anti-HBc]	<input type="checkbox"/>	
IgM antibody to hepatitis B core antigen [IgM anti-HBc]	<input type="checkbox"/>	
Nucleic Acid Testing for hepatitis B [HBV NAT]	<input type="checkbox"/>	
Hepatitis B Virus DNA Quantitative by PCR	<input type="checkbox"/>	
Hepatitis B virus DNA Qualitative by PCR	<input type="checkbox"/>	
Antibody to the hepatitis B surface antigen [anti-HBs]	<input type="checkbox"/>	
Hepatitis B e antigen [HBeAg]	<input type="checkbox"/>	
Antibody to hepatitis B e antigen [HBeAb or anti-HBe]	<input type="checkbox"/>	
Hepatitis B Virus Genotype		
Hepatitis B Virus Drug Resistant		

**Hepatitis C**

Antibody to hepatitis C virus [anti-HCV]	<input type="checkbox"/>	
Anti-HCV signal to cut-off ratio		
Supplemental anti-HCV assay [e.g., RIBA]	<input type="checkbox"/>	
HCV RNA [e.g., PCR]	<input type="checkbox"/>	
Quantitative Hepatitis C RT-PCR	<input type="checkbox"/>	
Qualitative Hepatitis C RT-PCR	<input type="checkbox"/>	
Hepatitis C Virus Genotype		

**Hepatitis D**

Antibody to hepatitis D virus [anti-HDV]	<input type="checkbox"/>	
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**Hepatitis E**

Antibody to hepatitis E virus [IgM anti-HEV]	<input type="checkbox"/>	
IgG hepatitis E antibody [IgG anti-HEV]	<input type="checkbox"/>	

**Other**

Interleukin-28		
Biopsy		
Fibroscan		

*Liver Enzyme Levels at Time of Diagnosis*

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

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### Epidemiologic Information

*The following questions are provided as a guide for the investigation of lifetime risk factors for HBV infection. Collection of risk factor information may provide useful information for the development and evaluation of programs to identify and counsel HBV-infected persons.*

Did the patient receive clotting factor concentrates produced prior to 1987? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Was the patient ever on long-term hemodialysis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Has the patient ever injected drugs not prescribed by a doctor even if only once or a few times? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
How many sex partners has the patient had (approximate lifetime)?	Was the patient ever incarcerated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Was the patient ever treated for a sexually transmitted disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was the patient ever a contact of a person who had hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, type of contact: Household (Non-sexual) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Sexual <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Other (specify) _____	Was the patient ever employed in a medical or dental field involving direct contact with human blood? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
What is the country of birth for the mother?	Has the patient received medication for the type of hepatitis being reported? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	



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.

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First Name

Last Name

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**Other Information cont.**

Comments or Additional Information

Case ID

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**Case Notes**

Notes

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