# 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 | 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<br>###-###-#### | 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

**If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case?**

○ *Yes* ○ *No* ○ *Unknown*

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

**Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection?**

○ *Yes* ○ *No* ○ *Unknown*

**If yes, was the contact a:**

○ *Household member (non-sexual)* ○ *Sex partner* ○ *Child cared for by this patient*
○ *Babysitter of this patient* ○ *Playmate* ○ *Other (specify)*_____

**Was the patient a child or employee in a day care center, nursery, or preschool?**

○ *Yes* ○ *No* ○ *Unknown*

**Was the patient a household contact of a child or employee in a day care center, nursery, or preschool?**

○ *Yes* ○ *No* ○ *Unknown*

**If yes for either of those, was there an identified hepatitis A case in the child care facility?**

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

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

**Was the patient employed as a food handler during the two weeks prior to onset of symptoms or while ill?**

○ *Yes* ○ *No* ○ *Unknown*

**Did the patient travel outside of the U.S.A. or Canada in the two to six weeks before symptom onset?**

○ *Yes* ○ *No* ○ *Unknown*

| If Yes, where? |
|---|
| (Country) |
| |
| |
| |

**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) |
| |
| |
| |

## 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

# 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 | | | |
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| Did the person consume raw seafood? | If yes, specify type. | If yes, specify location. |
|---|---|---|
| ○ *Yes* ○ *No* ○ *Unknown* | | |

# Lab Results

| Report Date | Test Name | Test Result | Specimen | Collection Date |
|---|---|---|---|---|
| mm/dd/yyyy | | | | mm/dd/yyyy |
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## 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*

## Other Information

| Local 1 | Local 2 |
|---|---|
| | |

| Name of Person interviewed | Relationship to patient | Date of interview<br>mm/dd/yyyy |
|---|---|---|
| | | |

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

## Other Information cont.

**Comments or Additional Information**