

Viral Hepatitis Case Report

Perinatal Hepatitis B Virus Infection
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	

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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 <i>mm/dd/yyyy</i> _____	Discharge Date <i>mm/dd/yyyy</i> _____	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: <i>mm/dd/yyyy</i> _____	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: <i>mm/dd/yyyy</i> _____	

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: <i>mm/dd/yyyy</i> _____
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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	<input type="checkbox"/>	
Hepatitis B Virus Drug Resistant	<input type="checkbox"/>	
Hepatitis C		

Antibody to hepatitis C virus [anti-HCV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-HCV signal to cut-off ratio	<input type="text"/>	<input type="text"/>	<input type="text"/>
Supplemental anti-HCV assay [e.g., RIBA]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HCV RNA [e.g., PCR]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quantitative Hepatitis C RT-PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualitative Hepatitis C RT-PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C Virus Genotype	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis D			
Antibody to hepatitis D virus [anti-HDV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis E			
Antibody to hepatitis E virus [IgM anti-HEV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IgG hepatitis E antibody [IgG anti-HEV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other			
Interleukin-28	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroscan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Enzyme Levels at Time of Diagnosis			
Test Name	Result	Upper Limit Normal	Date of Result
			<i>(mm/dd/yyyy)</i>
ALT (SGPT)	<input type="text"/>	<input type="text"/>	<input type="text"/>
AST (SGOT)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Case ID

First Name

Last Name

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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

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Other Information				
Local 1		Local 2		
Name of Person interviewed	Relationship to patient	Date of interview <i>mm/dd/yyyy</i>		
Submitted by:	Date <i>mm/dd/yyyy</i>	Health Department	Phone Number <i>###-###-####</i>	Ext.

Case ID

First Name

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Other Information cont.

Comments or Additional Information

Case ID

First Name

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Case Notes

Notes

Empty text area for case notes.