Viral Hepatitis Case Report

Acute Hepatitis B

Michigan Department of Health and Human Services

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)*

Investigation Status	Case Status				
Active	○ Confirmed	○ Confirmed - Non Resident	○ Not a Case	☐ State Prison Case	
	○ Probable	○ Suspect	○ Unknown	○ Non-Michigan Case	

Patient Status	Patient Status Date *(mm/dd/yyyy)*	Case Disposition	Case Updated Date *(mm/dd/yyyy)*	Case Completion Date *(mm/dd/yyyy)*
Alive				

Date of Death *(mm/dd/yyyy)*

Investigator First Name: Last Name:	Part of an outbreak?	Outbreak Name

Patient Information

Patient ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone *(###-###-####)*	Ext.	Other Phone *(###-###-####)*	Ext.

Email Address

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)*

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

☐ Other (Specify) ☐ Unknown ☐ Refused to answer

Hispanic Ethnicity	Arab Ethnicity
○ Hispanic/Latino ○ Non-Hispanic/Latino ○ Unknown ○ Refused to answer	○ Arab ○ Non-Arab ○ Unknown ○ Refused to answer

Worksites/School	Occupations/Grade	MDOC ID

Referral Information

Person Providing Referral

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

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Referral Information Continued

Primary Physician				
First	Last	Phone *(###-###-####)*	Ext.	Email
Street Address				
City	County	State		Zip

Hospital Information

Patient Hospitalized ○ Yes ○ No ○ 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:	If other Place of Birth:

Did the patient die from hepatitis? ○ Yes ○ No ○ Unknown	If yes, specify the date of death: *(mm/dd/yyyy)*	Was the patient aware they had viral hepatitis prior to lab testing? ○ Yes ○ No ○ Unknown

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

Reason for Testing: *(Check all that apply)*

- ☐ Year of birth (1945-1965)
- ☐ Symptoms of acute hepatitis
- ☐ Screening of asymptomatic patient with reported risk factors
- ☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- ☐ Evaluation of elevated liver enzymes
- ☐ Blood / Organ donor screening
- ☐ Follow-up testing for previous marker of viral hepatitis
- ☐ Unknown

☐ Prenatal screening
☐ Other

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

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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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)			
Bilirubin (mg/dL)			

Epidemiologic Information

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

Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection? ○ Yes ○ No ○ Unknown	If yes, type of contact Sexual ○ Yes ○ No ○ Unknown Household (Non-sexual) ○ Yes ○ No ○ Unknown Other	
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	
Did the patient undergo hemodialysis? ○ Yes ○ No ○ Unknown	Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? ○ Yes ○ No ○ Unknown	
Did the patient receive blood or blood products (transfusion)? ○ Yes ○ No ○ Unknown	If yes, when? *mm/dd/yyyy*	Did the patient receive any IV infusions and/or injections in the outpatient setting? ○ Yes ○ No ○ Unknown
Did the patient have other exposure to someone else's blood? ○ Yes ○ No ○ Unknown	If yes, specify:	
Was the patient employed in a medical or dental field involving direct contact with human blood? ○ Yes ○ No ○ Unknown	If yes, frequency of direct blood contact: ○ Frequent (several times weekly) ○ Infrequent	
Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood? ○ Yes ○ No ○ Unknown	If yes, frequency of direct blood contact: ○ Frequent (several times weekly) ○ Infrequent	
Did the patient receive a tattoo? ○ Yes ○ No ○ Unknown	If yes, where was the tattooing performed? *(Check all that apply)* ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other (specify)	
Did the patient have any part of their body pierced (other than ear)? ○ Yes ○ No ○ Unknown	If yes, where was the piercing performed? *(Check all that apply)* ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other (specify)	
Did the patient have dental work or oral surgery? ○ Yes ○ No ○ Unknown	Did the patient have surgery? (other than oral surgery) ○ Yes ○ No ○ Unknown	Was the patient hospitalized? ○ Yes ○ No ○ Unknown

Was the patient a resident of a long term care facility?
○ Yes ○ No ○ Unknown

Was the patient incarcerated for longer than 24 hours?
○ Yes ○ No ○ Unknown

If yes, what type of facility? *(Check all that apply)*
Jail ○ Yes ○ No
Juvenile facility ○ Yes ○ No
Prison ○ Yes ○ No

During his/her lifetime, was the patient EVER incarcerated for longer than 6 months?
○ Yes ○ No ○ Unknown

If yes, what year was the most recent incarceration?
yyyy

If yes, for how long? *(months)*

Did patient have a negative HBsAg test within 6 months prior to positive test?
○ Yes ○ No ○ Unknown

Verified test date: mm/dd/yyyy

Was the patient tested for hepatitis D?
○ Yes ○ No ○ Unknown

Did patient have a co-infection with hepatitis D?
○ Yes ○ No ○ Unknown

Was the patient EVER treated for a sexually transmitted disease?
○ Yes ○ No ○ Unknown

If yes, in what year was the most recent treatment? *yyyy*

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

In the 6 months prior to symptom onset, how many male sex partners did the patient have?
○ 0 ○ 1 ○ 2-5 ○ >5 ○ Unknown

In the 6 months prior to symptom onset, how many female sex partners did the patient have?
○ 0 ○ 1 ○ 2-5 ○ >5 ○ Unknown

Vaccine History

Did the patient ever receive hepatitis B vaccine?
○ Yes ○ No ○ Unknown

If yes, how many shots?
○ 1 ○ 2 ○ 3 or more

In what year was the last shot received? *yyyy*

Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?
○ Yes ○ No ○ Unknown

If yes, was the serum anti-HBs >= 10mIU/ml? (answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')
○ Yes ○ No ○ 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.
Comments or Additional Information				

Case Notes

Notes

Lab Results

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

No Labs