Viral Hepatitis Case Report

Acute Hepatitis C

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: Active

Case Status: ○ Confirmed ○ Confirmed - Non Resident ○ Not a Case ○ Probable ○ Suspect ○ Unknown ○ Non-Michigan Case

☐ State Prison Case

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

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: ○ Male ○ Female ○ Unknown

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

Age

Age Units: ○ Days ○ Months ○ Years

Race *(Check all that apply)*

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

☐ Other (Specify) ☐ Unknown

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

Arab Ethnicity: ○ Arab ○ Non-Arab ○ Unknown

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	Hospital	Hospital City	Hospital Record No.
○ Yes ○ No ○ Unknown			

Admission Date *(mm/dd/yyyy)*	Discharge Date *(mm/dd/yyyy)*	Days Hospitalized

Clinical Information and Patient History

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

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

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)
- ☐ 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: *(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)			

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Epidemiologic Information

Please answer the following questions for the time period 2 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 C 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

Verified test date: mm/dd/yyyy

Did the patient have a negative HCV antibody test in the 12 months prior to a positive HCV antibody test result?
○ Yes ○ No ○ Unknown

Did the patient have a negative HCV antibody or RNA reported in the 12 months prior to a positive HCV RNA test result?
○ 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)

Has the patient received medication for the type of hepatitis being reported?
○ Yes ○ No ○ Unknown

Was the patient EVER treated for a sexually

If yes, in what year was the most

What is the sexual preference of the patient?

transmitted disease?	recent treatment?*yyyy*	
○ Yes ○ No ○ Unknown		○ Heterosexual ○ Homosexual ○ Bisexual ○ Unknown

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

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Case Management Data

Contact Type	Date *(mm/dd/yyyy)*	Interview Result

Lost to follow-up? ○ Yes ○ No ○ Unknown

Insurance Status *(Check all that apply)*

☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Uninsured ☐ Other

Was the client provided with viral hepatitis education? *(Check all that apply)*

☐ Yes - General information ☐ Yes - Specific test results ☐ No education provided

Does the patient have a provider of care for Hepatitis C?

○ Yes ○ No ○ In progress ○ Unknown

Treated by provider*(report contact information only if different than primary provider, ex. HCV Treatment Prescriber)*

Select treatment provider specialty: *(Check all that apply)*

☐ Gastroenterologist ☐ Hepatologist ☐ Infectious Disease Specialist ☐ Primary Care / Family Care

☐ Other, specify

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

Street Address

City	County	State	Zip

Is or has the patient's Hepatitis C infection been treated?

○ Yes ○ No ○ In progress ○ Unknown

If 'Yes' or 'In progress'

Treatment start date

Medication ○ Epclusa ○ Mavyret ○ Harvoni ○ Zepatier ○ Other

Treatment end date

Were any referrals made for the patient? *(Check all that apply)*

☐ Primary Care Physician ☐ HCV Treatment Provider ☐ Insurance ☐ Housing ☐ Food

☐ Transportation ☐ Syringe Service Program ☐ Medication Assisted Treatment ☐ Other

☐ The patient has cleared the virus

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

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Case Notes

Notes

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Lab Results

Report Date	Test Name	Reported Test Name/Test Result	Specimen	Collection Date
(mm/dd/yyyy)				*(mm/dd/yyyy)*
No Labs				