Viral Hepatitis Case Report

Perinatal Hepatitis B Virus Infection

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.

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

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

Race of Mother:
◯ Caucasian ◯ Black/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*

– 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

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– Lab Results

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