

VIRAL HEPATITIS B OR C
CASE REPORT



Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
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www.lapublichealth.org/acd

Census tract: _____ VCMR ID: _____

Patient name-last		first	middle initial	Date of Birth	Age	Sex
Address- number, street			City	State	ZIP Code	
Telephone number Home ()	Work ()	Cell ()		Country of Birth		
Race (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____				Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____						
Occupation or school (give city/zip code)			Homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>	Sensitive Occupation/Situation(S.O.S)? Yes <input type="checkbox"/> No <input type="checkbox"/>		

PRESENT ILLNESS

Diagnosis date: _____	Was the patient hospitalized for hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, admit date: _____	Medical Record No.
Was patient jaundiced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, start date: _____	Facility/Hospital Name:	
Did patient have symptoms other than jaundice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, onset date: _____	If female: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, due date: _____	
What symptoms? _____	Did patient die from hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, date of death: _____	

VACCINE HISTORY

	Yes	No	Unk	If Yes, Date dose given. 1 st Dose	2 nd Dose	3 rd Dose
hepatitis A vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
hepatitis B vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

DIAGNOSTIC TESTS (Check all tests performed and attach laboratory results.)

Reason for testing: (Check all that apply)	Laboratory results:	Pos	Neg	No Test/Unk
<input type="checkbox"/> Symptoms of acute hepatitis	Total antibody to hepatitis A virus (total anti-HAV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Evaluation of elevated liver enzymes	IgM antibody to hepatitis A virus (IgM anti-HAV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exposure to case	Total antibody to hepatitis B core antigen (total anti-HBc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis	IgM antibody to hepatitis B core antigen (IgM anti-HBc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Routine screening of patient (physical exam, MD visit, pre-op)	Hepatitis B surface antigen (HBsAg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood/organ donor screening	Antibody to hepatitis B surface antigen (anti-HBs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prenatal screening	HCV antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unknown	Antibody to hepatitis C virus (anti-HCV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	HCV Nucleic Acid Test (e.g. NAT, PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____	HCV Genotype _____			
	Antibody to hepatitis D virus (IgM anti-HDV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Antibody to hepatitis E virus (IgM anti-HEV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Liver enzyme results at time of diagnosis:
Test Result Date: _____ ALT (SGPT) _____ AST (SGOT) _____ Bilirubin _____

PUBLIC HEALTH NURSING INITIAL ASSESSMENT AND EVALUATION

If acute hepatitis (check here), please complete the remainder of this form. See Page 3 for acute hepatitis B and C definitions.

If **NOT** acute hepatitis (check here), please go to **Final Diagnosis** section and complete.

HOUSEHOLD/SEXUAL CONTACTS

Name/ Relationship to case	Age	Prior history of Hepatitis B Vaccine			Hepatitis B Vaccine given			Date vaccine given	Comments (include Prophylaxis and/or Vaccine)
		Yes	No	Unk	Yes	No	Unk		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

EPIDEMIOLOGIC RISK FACTORS

	Yes	No	Unk
Was the patient EVER treated for a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient EVER denied from donating blood due to hepatitis infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the 6 months prior to onset of symptoms: If YES, ask patient when and where and record in Remarks section.

- Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B or C virus infection? Yes No Unk
 - If Yes, contact type: Sexual Household (Non-sexual) Injection drug use Occupation Other: _____
- Did the patient undergo hemodialysis? Yes No Unk
- Was the patient a resident of a long term facility (e.g. nursing home)? Yes No Unk
- Did the patient receive fingersticks? Yes No Unk
- Did the patient receive blood or blood products (transfusion)? Yes No Unk
- Did the patient receive any IV infusions and/or injections? Yes No Unk
- Did the patient have prior history of hospitalization? Yes No Unk
- Did the patient have dental work or oral surgery? Yes No Unk
- Did the patient have surgery other than oral surgery? Yes No Unk
- Did the patient have any outpatient medical procedure or surgery (e.g. colonoscopy, endoscopy)? Yes No Unk
- Did the patient have any podiatric procedures? Yes No Unk
- Did the patient donate blood? Yes No Unk
 - Date of last blood donation. _____ Location of last donation. _____
- Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? Yes No Unk
- Did the patient have other exposure to someone else's blood? Yes No Unk
- Did the patient have a manicure or pedicure? Yes No Unk
- Did the patient undergo acupuncture? Yes No Unk
- Did the patient receive a tattoo? Yes No Unk
 - If Yes, where was the tattooing performed? Commercial parlor/shop Correctional facility Other _____
- Did the patient have any part of their body pierced (other than ear)? Yes No Unk
 - If Yes, where was the piercing performed? Commercial parlor/shop Correctional facility Other _____
- Did the patient inject drugs not prescribed by a doctor? Yes No Unk
- Did the patient use street drugs but not inject? Yes No Unk
 - If Yes, when? _____ What kind of drugs? _____
- How many sex partners did the patient have? (Ask both questions regardless of the patient's gender.)
 - Number of male sex partners 0 1 2-5 >5 Unk
 - Number of female sex partners 0 1 2-5 >5 Unk
- Was the patient incarcerated for longer than 24 hours? Yes No Unk
 - If Yes, what type of facility (Check all that apply) Prison Jail Juvenile facility

EPIDEMIOLOGIC RISK FACTORS (Continued)

During the 6 months prior to onset of symptoms: If YES, ask patient when and where and record in Remarks section.	Yes	No	Unk
Was the patient employed in a medical or dental field involving direct contact with human blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient employed as a public safety worker (fire fighter, law enforcement/correctional officer) having direct contact with human blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indication of recent seroconversion			
Negative HBsAg result within 6 months prior to HBV diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative Anti-HCV result within 12 months prior to HCV diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS (Please explain any YES answers in Epidemiologic Risk Factor section. Please sign your notes.)

Suspected Source

Educated patient according to B-73 on the following:

<u>Mode of Transmission:</u>	<u>Prevention:</u>	<u>Other:</u>
<input type="checkbox"/> Blood to blood	<input type="checkbox"/> Household Contacts	
<input type="checkbox"/> Sexual	<input type="checkbox"/> Vaccine	
<input type="checkbox"/> Maternal Infant Transmission	<input type="checkbox"/> Personal Hygiene	
	<input type="checkbox"/> Immunoglobulin (HBIG)	

FINAL DIAGNOSIS

<input type="checkbox"/> Acute Hepatitis B <input type="checkbox"/> False Hepatitis B <input type="checkbox"/> Chronic Hepatitis B <input type="checkbox"/> Acute Hepatitis C: <input type="checkbox"/> False Hepatitis C <input type="checkbox"/> Chronic Hepatitis C <input type="checkbox"/> Confirmed <input type="checkbox"/> False Hepatitis D <input type="checkbox"/> Chronic Hepatitis D <input type="checkbox"/> Probable <input type="checkbox"/> Could not confirm: Why? <input type="checkbox"/> Acute Hepatitis D <input type="checkbox"/> Unable to locate (UTL)	<p>Acute Hepatitis B or C Case Definition: An acute illness with: discrete onset of symptoms AND</p> <p><u>Hepatitis B:</u> 1) Jaundice or abnormal serum aminotransferase (ALT) levels >100 IU/L AND 2) HBsAg positive AND IgM anti-HBc positive (if done).</p> <p><u>Hepatitis C:</u> Confirmed 1) Jaundice or abnormal serum aminotransferase (ALT) levels >200 IU/L AND 2) Anti-HCV positive AND 3) Verified by HCV NAT positive OR HCV antigen* positive</p> <p>Probable 1) Jaundice or abnormal serum aminotransferase (ALT) levels >200 IU/L AND 2) Anti-HCV positive AND 3) NO report of HCV NAT positive OR NO HCV antigen* positive</p> <p><small>*When and if a test for HCV antigen(s) is approved by FDA and available.</small></p>
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Investigator's name (print)	Investigator's signature	Date	Telephone number ()
Health District	Supervisor signature	Area Medical Director's signature	