County of Los Angeles **Public Health**

VIRAL HEPATITIS C CASE REPORT

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
www.lapublichealth.org/acd

Reset Form

IRIS ID: _____

PATIENT INFORMATION

Patient Name - Last	First	Middle	Date of Birth	Age

Address - Number, Street	City	State	Zip Code

Telephone Number Home	Work	Cell	Email	Country of Birth	Date of Arrival

Patient's current gender identity? (check one)
☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth? (check one)
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: _____ ☐ Prefer not to answer

Patient's sexual orientation? (check one)
☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____
☐ Don't understand the question ☐ Prefer not to answer

Patient's race or ethnicity? (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Some other race; specify: _____ ☐ Refused
If Asian or Native Hawaiian/Other Pacific Islander, specify nationalities/ethnic groups: _____

Occupation, school, and/or volunteer (city/zip code)

Homeless? ☐ Yes ☐ No

Sensitive Occupation/Situation (S.O.S)? ☐ Yes ☐ No

CLINICAL INFORMATION

Diagnosis date: _____

Was patient jaundiced? ☐ Yes ☐ No ☐ Unknown

If Yes, start date: _____

Did patient have symptoms other than jaundice?
☐ Yes ☐ No ☐ Unknown If Yes, onset date: _____

What symptoms?

☐ Abdominal Pain	☐ Dark Urine	☐ Diarrhea
☐ Anorexia	☐ Clay stools	☐ Fever
☐ Headache	☐ Nausea	☐ Vomiting
☐ Fatigue	☐ Malaise	☐ Myalgia
☐ Joint pain	☐ Other (specify): _____	

Did the patient visit the emergency room for illness? ☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized for hepatitis?
☐ Yes ☐ No ☐ Unknown If Yes, add hospitalization details.

Medical Record Number

Facility/Hospital Name:

Admit date	Discharge date	Did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? ☐ Yes ☐ No ☐ Unknown

If female: Pregnant? ☐ Yes ☐ No ☐ Unknown If Yes, due date: _____

Did the patient develop fulminant hepatitis? ☐ Yes ☐ No ☐ Unknown

Did the patient die from hepatitis? ☐ Yes ☐ No ☐ Unknown If Yes, date of death: _____

VACCINE HISTORY *Look up case in CAIR and/or review other immunization records and indicate whether they received the 2 dose or 3 dose vaccine series.*

	Yes	No	Unk	If Yes, vaccine type/name	2 or 3 dose series?	1st Dose Date	2nd Dose Date	3rd Dose Date
Hepatitis A vaccine	☐	☐	☐		2 ☐ 3 ☐			
Hepatitis B vaccine	☐	☐	☐		2 ☐ 3 ☐			

If ≤18 Years and not vaccinated, specify why not vaccinated: _____

Reason for testing: (check all that apply)
☐ Symptoms of acute hepatitis
☐ Evaluation of abnormal liver biochemistries/liver function tests
☐ Exposure to case
☐ Routine screening of patient (physical exam, MD visit, pre-op)
☐ Blood/organ donor screening
☐ Prenatal screening
☐ Unknown
☐ Other (specify): _____

LABORATORY INFORMATION *(Check all tests performed and attach laboratory results.)*

Hepatitis A Diagnostic Tests	Positive	Negative	Borderline	Not Tested	Unknown	Specimen Collection Date
Total antibody to hepatitis A virus (total anti-HAV) ……....	☐	☐	☐	☐	☐	_____
IgM antibody to hepatitis A virus (IgM anti-HAV) ……..……	☐	☐	☐	☐	☐	_____
Hepatitis A virus PCR (HAV PCR) ……..……..……	☐	☐	☐	☐	☐	_____

HAV genotype _____

Patient Name (Last, First) _____ Date of Birth _____ IRIS ID: _____

LABORATORY INFORMATION – Continued *(Check all tests performed and attach laboratory results.)*

Hepatitis B Diagnostic Tests	Positive	Negative	Borderline	Not Tested	Unknown	Specimen Collection Date
Total antibody to hepatitis B core antigen (total anti-HBc) ……....	☐	☐	☐	☐	☐	_____
IgM antibody to hepatitis B core antigen (IgM anti-HBc) ……	☐	☐	☐	☐	☐	_____
Hepatitis B surface antigen (HBsAg) ……	☐	☐	☐	☐	☐	_____
Antibody to hepatitis B surface antigen (anti-HBs) ……	☐	☐	☐	☐	☐	_____
Hepatitis B e antigen (HBeAg) ……...	☐	☐	☐	☐	☐	_____
Antibody to hepatitis B e antigen (anti-HBe) ……	☐	☐	☐	☐	☐	_____
Hepatitis B Nucleic Acid Test (NAT) (HBV DNA) ……..……	☐	☐	☐	☐	☐	_____
Hepatitis C Diagnostic Tests						
Antibody to hepatitis C virus (anti-HCV) ……...	☐	☐	☐	☐	☐	_____
Hepatitis C Nucleic Acid Test (NAT) (HCV RNA) …….....	☐	☐	☐	☐	☐	_____
HCV genotype _____						
Other Viral Hepatitis Diagnostic Tests						
Antibody to hepatitis D virus (IgM anti-HDV) ……...	☐	☐	☐	☐	☐	_____
Hepatitis D Nucleic Acid Test (NAT) (HDV RNA) ……..……	☐	☐	☐	☐	☐	_____
Antibody to hepatitis E virus (IgM anti-HEV) ……...	☐	☐	☐	☐	☐	_____
Hepatitis E Nucleic Acid Test (NAT) (HEV RNA) ……..……	☐	☐	☐	☐	☐	_____

Liver enzyme results at time of diagnosis:

Specimen collection date: _____ ALT (SGPT) _____ AST (SGOT) _____ Total Bilirubin _____

Peak liver enzyme results:

ALT (SGPT) _____ Specimen collection date: _____ AST (SGOT) _____ Specimen collection date: _____

Total Bilirubin _____ Specimen collection date: _____

LINKAGE TO CARE

If patient is HCV RNA positive, was the patient linked to HCV care? ☐ Yes ☐ No ☐ Unknown If Yes, HCV treatment start date: _____

PUBLIC HEALTH NURSING INITIAL ASSESSMENT AND EVALUATION

If acute hepatitis (check here ☐), please complete the remainder of this form. See Page 5 for acute hepatitis C definition.

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

INFECTION TIMELINE

Incubation period: 2 weeks to 6 months, average 6-7 weeks.

Infectious period: Transmission can occur any time that HCV RNA is present in the blood.

Post-exposure prophylaxis: None.

If symptomatic, enter date of onset* in onset box. If asymptomatic, enter specimen collection date of first positive test in onset box. Count backward to determine probable exposure period.

EXPOSURE PERIOD

Days from onset:	**-6 months**		**-14 days**	**ONSET***
Calendar dates: *(month/day/year)*				

**onset of jaundice or onset of symptoms if not jaundiced*

CLOSE CONTACTS *(e.g., household and sexual contacts, persons using injection or non-injection drugs with the HCV-infected person)*

Name/ Relationship to case	Age	Screening Recommendation Provided Yes	No	Unk	Comments
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

Patient Name (Last, First) _____ Date of Birth _____ IRIS ID: _____

EPIDEMIOLOGIC RISK FACTORS *(Refer to Infection Timeline above)*

During the INCUBATION PERIOD: If YES, ask patient when and record additional details in Remarks section.	Yes	No	Unk
Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection?	☐	☐	☐
If Yes, contact type: ☐ Sexual ☐ Household (Non-sexual) ☐ Injection drug use ☐ Occupation ☐ Other: _____			
Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?	☐	☐	☐
If Yes, date: _____			
Did the patient have other exposure to someone else's blood?	☐	☐	☐
If Yes, date: _____			

During the INCUBATION PERIOD: If any treatments/procedures in healthcare facilities, indicate dates & facility details below.			
Did the patient receive blood or blood products (transfusion)?	☐	☐	☐
Did the patient receive an organ (transplant)?	☐	☐	☐
Did the patient undergo hemodialysis?	☐	☐	☐
Did the patient have prior history of hospitalization?	☐	☐	☐
Did the patient have any outpatient medical procedure or surgery (e.g. colonoscopy, endoscopy)?	☐	☐	☐
Did the patient receive any IV infusions and/or injections prescribed by a doctor?	☐	☐	☐
Did the patient have dental work or oral surgery?	☐	☐	☐
Did the patient have surgery other than oral surgery?	☐	☐	☐
Did the patient receive fingersticks or blood draw in home or clinic?	☐	☐	☐
Did the patient have any podiatric procedures?	☐	☐	☐
Did the patient receive chemotherapy treatment?	☐	☐	☐
Did the patient undergo acupuncture?	☐	☐	☐
Was the patient a resident of a long-term facility (e.g. nursing home)?	☐	☐	☐

If only risk factors are healthcare treatments/procedures, notify ACDC about potential healthcare acquired infection.

During the INCUBATION PERIOD: If any procedures in other exposure sites, indicate dates & details below.	Yes	No	Unk
Did the patient have any part of their body pierced (other than ear)?	☐	☐	☐
If Yes, where was the piercing performed? ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other: _____			
Did the patient receive a tattoo?	☐	☐	☐
If Yes, where was the tattooing performed? ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other: _____			
Did the patient have a manicure or pedicure?	☐	☐	☐
Did the patient have any other treatment or cosmetic procedure that penetrated the skin (e.g. head or neck shave)?	☐	☐	☐
If Yes, specify _____			

FACILITY OR OTHER POSSIBLE EXPOSURE SITE DETAILS

Facility/Site Name	Facility/Site Type *(clinic, hospital, etc.)*	Facility/Site Location *(address, location, phone #)*	Date of 1st procedure Or seen at facility/site	Date last seen at facility/site	Description of procedure/ exposure

	Yes	No	Unk
Did the patient inject drugs not prescribed by a doctor?	☐	☐	☐
Did the patient use street drugs but not inject?	☐	☐	☐

Drug Name	Route of Administration (e.g.: smoked, snorted, injected, taken by mouth)

Was the patient incarcerated for longer than 24 hours?	☐	☐	☐

If Yes, what type of facility (*Check all that apply*): ☐ Prison ☐ Jail ☐ Juvenile facility

EPIDEMIOLOGIC RISK FACTORS – Continued *(Refer to Infection Timeline above)*

During the INCUBATION PERIOD: If YES, ask patient when and record additional details in Remarks section.	Yes	No	Unk
Was the patient experiencing homelessness/unstable housing?	☐	☐	☐
How many sex partners did the patient have? (Ask questions regardless of the patient's gender.)			
Number of male sex partners: _____ ☐ Unknown ☐ Refused to answer			
Number of female sex partners: _____ ☐ Unknown ☐ Refused to answer			
Number of trans/non-binary sex partners: _____ ☐ Unknown ☐ Refused to answer			
Was the patient EVER treated for a sexually transmitted disease?	☐	☐	☐
Was the patient EVER denied from donating blood due to hepatitis infection?	☐	☐	☐
Did the patient donate blood?	☐	☐	☐
Date of last blood donation: _____ Location of last donation: _____			
Was the patient employed in a medical or dental field involving direct contact with human blood?	☐	☐	☐
Was the patient employed as a public safety worker (firefighter, law enforcement/correctional officer) having direct contact with human blood?	☐	☐	☐
Indication of recent seroconversion			
Negative Anti-HCV result within 12 months prior to HCV diagnosis	☐	☐	☐
If Yes, collection date: _____			
Negative HCV RNA result within 12 months prior to HCV diagnosis	☐	☐	☐
If Yes, collection date: _____			
Was the patient epi-linked to known case?	☐	☐	☐
If Yes, Contact Name/Case #: _____			
Was the patient a part of known outbreak?	☐	☐	☐
If Yes, extent of outbreak: ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other: _____			

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:

Mode of Transmission:
- ☐ Blood to Blood
- ☐ Sexual
- ☐ Maternal Infant Transmission

Prevention:
- ☐ Household Contacts
- ☐ Personal Hygiene

Other:
- ☐ Treatment

Patient Name (Last, First) _____ Date of Birth _____ IRIS ID: _____

FINAL DIAGNOSIS

☐ Acute Hepatitis C:
- ☐ Confirmed
- ☐ Probable

☐ Unable to locate (UTL)

☐ Could not confirm: Specify. _____

☐ Chronic Hepatitis C

☐ Not acute or chronic hepatitis C (False) _____

Does this case meet the binational case definition?

☐ Yes ☐ No ☐ Unknown

Binational Case Definition:

Any individual with a confirmed or probable case of a notifiable infectious disease, and:

1) Who has recently traveled or lived in Mexico, or had recent contact with persons who lived or traveled in Mexico; **OR**
2) Who is thought to have acquired the infection in Mexico or have been in Mexico during the incubation period of the infection and was possibly contagious during this period; **OR**
3) Who is thought to have acquired the infection from a product from Mexico; **OR**
4) Whose case requires the collaboration of both countries for the purposes of disease investigation and control.

Acute Hepatitis C Case Definition:

Confirmed Acute:

Must have the following:
1) Jaundice **OR** total bilirubin levels ≥3.0 mg/dL **OR** ALT levels >200 IU/L
2) HCV NAT positive **OR** HCV antigen* positive
3) Absence of a more likely diagnosis

OR

Any of the following for HCV seroconversion:
- Detection of anti-HCV within 12 months (365 days) of a negative anti-HCV test result **OR**
- Detection of HCV NAT within 12 months (365 days) of a negative anti-HCV test result **OR**
- Detection of HCV NAT within 12 months (365 days) of a negative HCV NAT test result in a person without a prior diagnosis of hepatitis C

OR

Reinfection:
At least 2 sequential documented negative HCV detection tests at least 12 weeks apart in someone with a prior hepatitis C diagnosis followed by a positive HCV detection test.

Probable Acute:

Must have the following:
1) Jaundice **OR** total bilirubin levels ≥3.0 mg/dL **OR** ALT levels >200 IU/L
2) Detection of anti-HCV
3) HCV NAT not done
4) Absence of a more likely diagnosis

*When and if a test for HCV antigen(s) is approved by FDA and available.

Investigator's name (print)	Investigator's signature	Date	Telephone number

Health District	Supervisor signature	Area Medical Director's signature