

Hepatitis Case Investigation

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control
 Infectious Disease Epidemiology Program
 Phone: 304-558-5358 or 800-423-1271 in West Virginia
 Fax: 304-558-8736

Disease Under Investigation

* indicates required fields

Does patient also have:
 (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Acute hepatitis A | <input type="checkbox"/> Acute hepatitis B | <input type="checkbox"/> Acute hepatitis C |
| <input type="checkbox"/> Acute hepatitis E | <input type="checkbox"/> Chronic HBV infection | <input type="checkbox"/> HCV infection (chronic or resolved) |
| <input type="checkbox"/> Acute non-ABCD hepatitis | <input type="checkbox"/> Perinatal HBV infection | <input type="checkbox"/> Hepatitis Delta (co- or super-infection) |

Investigation Status*

- Closed
 Open
 Regional Review
 State Review
 Superseded
 Unassigned

Case Status*

- Confirmed
 Not a Case
 Probable
 Suspect
 Unknown

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial
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Street Address

City	County	State West Virginia	Zip
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Is the patient's residence a:

- Correctional Facility (Specify) _____
 Long Term Care Facility (Specify) _____
 Shelter or Group Home (Specify) _____
 None of the above

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy
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Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient
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Check if address is same as above; otherwise complete guardian contact information below

Guardian Street Address

City	County	State West Virginia	Zip
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Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.
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Patient Demographic Information

* indicates required fields

Sex
 Male Female Transsexual Unknown Failure to report sex/missing sex Other (Specify) _____

Date of Birth* <small>mm/dd/yyyy</small>	Country of Birth <input type="radio"/> U.S. <input type="radio"/> Other (Specify) _____	Age	Age Units <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years
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Ethnicity
 Hispanic or Latino Not Hispanic or Latino Unknown Failure to report ethnicity/missing ethnicity

Race
 (Check all that apply)

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander _____
<input type="checkbox"/> White	<input type="checkbox"/> Unknown
<input type="checkbox"/> Failure to report race/missing race	<input type="checkbox"/> Some Other Race _____

Outcome and Clinical Information

Reason for Testing:
 (Check all that apply)

<input type="checkbox"/> Symptoms of acute hepatitis	<input type="checkbox"/> Evaluation of elevated liver enzymes
<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors	<input type="checkbox"/> Blood / Organ donor screening
<input type="checkbox"/> Screening of asymptomatic patient with no risk factors <i>(e.g., patient requested)</i>	<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis
<input type="checkbox"/> Prenatal screening	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other (Specify) _____	

Was patient hospitalized for this disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Name of Hospital	Date of Admission <small>mm/dd/yyyy</small>
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Patient outcome from this disease: <input type="radio"/> Died <input type="radio"/> Survived <input type="radio"/> Unknown	Date of Death <small>mm/dd/yyyy</small>
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Clinical Data

Date of diagnosis <small>mm/dd/yyyy</small>	Is the patient symptomatic? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, onset date: <small>mm/dd/yyyy</small>	Was the patient jaundiced? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
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Was the patient pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Due date: <small>mm/dd/yyyy</small>
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Diagnostic Tests

* indicates required fields

Total antibody to hepatitis A virus [total anti-HAV]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	IgM antibody to hepatitis A virus [IgM anti-HAV]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	
Hepatitis B surface antigen [HBsAg]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown		
Total antibody to hepatitis B core antigen [Total anti-HBc]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	IgM antibody to hepatitis B core antigen [IgM anti-HBc]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	
Antibody to hepatitis C virus [anti-HCV]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	anti-HCV signal to cut-off ratio*	Supplemental anti-HCV assay [e.g. RIBA]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown
HCV RNA [e.g. PCR]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	Antibody to hepatitis D virus [anti-HDV]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown	Antibody to hepatitis E virus [anti-HEV]* <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown

Liver Enzyme Levels at Time of Diagnosis

Test Name	Result	Upper Limit Normal	Date of Result
			mm/dd/yyyy
ALT (SGPT)			
AST (SGOT)			

Reporting Source

Last Name		First Name	
Phone ###-###-####	Ext.	Fax ###-###-####	
Facility			
Address			
City	State West Virginia	Zip	
E-mail			

Provider with Further Patient Information

Last Name		First Name	
Phone ###-###-####	Ext.	Fax ###-###-####	
Address			
City	State West Virginia	Zip	

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy	
Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####
Ext.			
Investigation ID	Part of an Outbreak? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Outbreak Name	Lost to follow-up? <input type="radio"/> Yes <input type="radio"/> No

Risk Factor Investigation

Acute Hepatitis A

If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case?

Yes No Unknown

During the 2 - 6 weeks prior to onset of symptoms:

Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection?

Yes No Unknown

If Yes, was the contact:

Household member (non-sexual) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Sex partner <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Child cared for by this patient <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Babysitter of this patient <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
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Playmate
 Yes No Unknown

Other (Specify)

During the 2 - 6 weeks prior to onset of symptoms, was the patient:

A child or employee in a day care center, nursery, or preschool?

Yes No Unknown

A household contact of a child or employee in a day care center, nursery, or preschool?

Yes No Unknown

If Yes for either of those, was there an identified hepatitis A case in the child care facility?

Yes No Unknown

Please ask both of the following questions regardless of the patient's gender. In the 2 - 6 weeks prior to symptom onset:

How many male sex partners did the patient have?

0 1 2-5 >5 Unknown

How many female sex partners did the patient have?

0 1 2-5 >5 Unknown

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 travel outside of the U.S.A. or Canada in the 2 - 6 weeks before symptom onset?

Yes No Unknown

If Yes, where?

(Country)

In the 3 months prior to symptom onset, did anyone in the patient's household travel outside of the U.S. or Canada?

Yes No Unknown

If Yes, where?

(Country)

Is the patient suspected as being part of a common-source outbreak?

Yes No Unknown

Foodborne - associated with an infected food handler

Yes No Unknown

Foodborne - NOT associated with an infected food handler

Yes No Unknown

Specify food item

Waterborne

Yes No Unknown

Source not identified

Yes No Unknown

Acute Hepatitis A cont.

Was the patient employed as a food handler during the TWO WEEKS prior to onset of symptoms or while ill?

Yes No Unknown

Vaccination History

Has patient ever received the hepatitis A vaccine?

Yes No Unknown

If Yes, how many doses?

One Dose Two or More Doses

If Yes, what year was the last dose received?

YYYY

Has the patient ever received immune globulin?

Yes No Unknown

If Yes, when was the last dose received?

mm/YYYY

Describe public health action taken

Risk Factor Investigation

Acute Hepatitis B

During the 6 weeks - 6 months prior to 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, was type of contact:

Sexual

Yes No Unknown

Household (Non-sexual)

Yes No Unknown

Other

Yes (Specify) _____ No Unknown

Ask both of the following questions regardless of the patient's gender. In the 6 months before symptom onset how many:

Male sex partners did the patient have?

0 1 2-5 >5 Unknown

Female sex partners did the patient have?

0 1 2-5 >5 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

During the 6 weeks - 6 months prior to onset of symptoms:

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) _____

Acute Hepatitis B cont.

Did the patient have any part of their body pierced (other than ear)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, where was the piercing performed? (Check all that apply) <input type="checkbox"/> Commercial parlor/shop <input type="checkbox"/> Correctional facility <input type="checkbox"/> Other (Specify) _____	
Did the patient have dental work or oral surgery? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Did the patient have surgery? (other than oral surgery) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Was the patient hospitalized? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was the patient a resident of a long term care facility? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Was the patient incarcerated for longer than 24 hours? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
If yes, was the facility a:			
Prison <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Jail <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Juvenile facility <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
During his/her lifetime, was the patient EVER incarcerated for longer than 6 months? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, what year was the most recent incarceration? YYYY	If yes, for how long? (months)
Did the patient ever receive hepatitis B vaccine? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, how many shots? <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, was the serum anti-HBs \geq 10mIU/ml? (answer 'Yes' if the laboratory result was reported as 'positive' or 'reactive') <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Describe public health action taken			

Risk Factor Investigation

Perinatal Hepatitis B Virus Infection

Race of Mother: (Check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander _____ <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Failure to report race/missing race <input type="checkbox"/> Some Other Race _____			
Ethnicity of Mother: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unknown <input type="radio"/> Failure to report ethnicity/missing ethnicity			
Was Mother born outside of the United States? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If Yes, what Country?	
Was the Mother confirmed HBsAg positive prior to or at time of delivery? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If No, was the mother confirmed HBsAg positive after delivery? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Date of HBsAg positive test result: mm/dd/yyyy
How many doses of hepatitis B vaccine did the child receive? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 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)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If Yes, on what date did the child receive HBIG? mm/dd/yyyy	
Describe public health action taken			

Risk Factor Investigation

Acute Hepatitis C

During the 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, was type of contact:

Sexual <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Household (Non-sexual) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Other <input type="radio"/> Yes (Specify) _____ <input type="radio"/> No <input type="radio"/> Unknown
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Ask both of the following questions regardless of the patient's gender. In the 6 months before symptom onset how many:

Male sex partners did the patient have? 0 1 2-5 >5 Unknown**Female sex partners did the patient have?** 0 1 2-5 >5 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

During the 2 weeks - 6 months prior to onset of symptoms:

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, was the facility a:

Prison <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Jail <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Juvenile facility <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
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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)

Acute Hepatitis C cont.

Describe public health action taken

Risk Factor Investigation

Hepatitis C Virus Infection (chronic or resolved)

The following questions are provided as a guide for the investigation of lifetime risk factors for HCV infection. Routine collection of risk factor information for persons who test HCV positive is not required. However, collection of risk factor information for such persons may provide useful information for the development and evaluation of programs to identify and counsel HCV-infected persons.

Did the patient receive a blood transfusion prior to 1992? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Did the patient receive an organ transplant prior to 1992? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Did the patient receive clotting factor concentrates produced prior to 1987? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Was the patient ever on long-term hemodialysis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Has the patient ever injected drugs not prescribed by a doctor even if only once or a few times? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		How many sex partners has the patient had (approximate lifetime)?	
Was the patient ever incarcerated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Was the patient ever treated for a sexually transmitted disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Was the patient ever a contact of a person who had hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
If yes, was type of contact:			
Sexual <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Household (Non-sexual) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Other <input type="radio"/> Yes (Specify) _____ <input type="radio"/> No <input type="radio"/> Unknown	
Was the patient ever employed in a medical or dental field involving direct contact with human blood? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			

Public Health Action Taken

Describe public health action taken