

# Acute Hepatitis A

## PATIENT DEMOGRAPHICS

<b>Name:</b> (last, first): _____ <b>Address</b> (mailing): _____ <b>Address</b> (physical): _____ <b>City/State/Zip:</b> _____ <b>Phone</b> (home): _____ <b>Phone(work/cell):</b> _____ <i>Alternate contact:</i> <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other <i>Name:</i> _____ <i>Phone:</i> _____	<b>Birth date:</b> __/__/____ <b>Age:</b> ____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk <b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Asian <input type="checkbox"/> Unk
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## INVESTIGATION SUMMARY

**Investigation Start Date:** \_\_/\_\_/\_\_\_\_ **Investigator:** \_\_\_\_\_ **Investigator phone:** \_\_\_\_\_

**REPORT SOURCE/HEALTHCARE PROVIDER (HCP)**

Report Source:  Laboratory  Hospital  Private Provider  Public Health Agency  Other – Specify \_\_\_\_\_

Reporter Name: \_\_\_\_\_ Reporter Phone: \_\_\_\_\_

**Earliest date reported to LHD:** \_\_/\_\_/\_\_\_\_ **Earliest date reported to State:** \_\_/\_\_/\_\_\_\_

## CLINICAL

Primary HCP Name: _____ Primary HCP Phone: _____ <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient hospitalized for this illness If yes, hospital name: _____ Patient Chart # _____ (if available) Admin Date: __/__/____ Discharge Date: __/__/____  Place of Birth: _____ <b>Reason for testing (check all that apply)</b> <input type="checkbox"/> Symptoms of acute hepatitis <input type="checkbox"/> Screening of asymptomatic patient with reported risk factors <input type="checkbox"/> Screening of asymptomatic patient with no risk factor, e.g. patient request <input type="checkbox"/> Evaluation of elevated liver enzymes <input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis <input type="checkbox"/> Blood/Organ donor screening <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____ <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Is patient pregnant? If yes, Due Date _____ <b>Diagnosis date:</b> __/__/____	<b>Clinical Findings</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Is patient symptomatic? <b>Illness Onset date:</b> __/__/____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Did the patient die from this illness? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal pain/right upper quadrant pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dark Urine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Clay colored stool <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anorexia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Malaise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever
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## LABORATORY (Please submit copies of ALL Labs associated with this illness to state health department)

ALT Result _____ Upper Limits _____ Date: _____ <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Total antibody to hepatitis A virus (total anti-HAV) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IgM antibody to hepatitis A virus (IgM anti-HAV) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis B surface antigen (HBsAg) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis B 'e' antigen (HBeAg) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Total antibody to hepatitis B core antigen (Total anti-HBc) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IgM antibody to hepatitis B core antigen (IgM anti-HBc) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HBV DNA	AST Result _____ Upper Limits _____ Date: _____ <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Antibody to hepatitis C virus (anti-HCV) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> anti-HVC signal to cut-off ratio <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Supplemental anti-HCV assay (e.g. RIBA) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HCV RNA (e.g. PCR) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Antibody to hepatitis D virus (anti-HDV) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Antibody to hepatitis E virus (anti-HEV)
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## EPIDEMIOLOGIC

Case Status:  Confirmed  Probable  Suspect  Not a Case  Unknown

Diagnosis:  Hepatitis A, Acute  Hepatitis B, Acute  Hepatitis B, Chronic  Perinatal Hepatitis B infection  
 Hepatitis C, Acute  Hepatitis C, Chronic (past or present)  Hepatitis Delta  Hepatitis E, Acute

**INFECTION TIMELINE****Instructions:**

Enter onset date in grey box. Count backward to determine probable exposure period

Days from onset

Calendar dates:

Exposure period

-50 (Max Incubation)	-14 (Min Incubation)
_ / _ / _	_ / _ / _

Onset date

↓

\_ / \_ / \_

**HEPATITIS A EXPOSURES (based on the above exposure period, unless otherwise specified)****DURING THE 2 – 6 WEEKS PRIOR TO ONSET OF SYMPTOMS DID/WAS THE PATIENT:****Y N U**

- A contact of a person with confirmed or suspected Hepatitis A virus infection? If yes, type of contact
- Babysitter of this patient
  - Child cared for by this patient
  - Household member (non-sexual)
  - Playmate
  - Other (Specify) : \_\_\_\_\_
- A child or employee in a daycare center, nursery or preschool?
- A household contact of a child or employee in a daycare center nursery or preschool?
- If yes for either of these, was there an identified Hepatitis A case in the child care facility?

**ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER:**

How many male sex partners did patient have

0 1 2 – 5  >5 Unknown

How many female sex partners did patient have

0 1 2 – 5  >5 Unknown**Y N U**

- Inject street drugs
- Use street drugs but not inject
- Travel outside the U.S.A. or Canada?  
If yes, where did they travel? \_\_\_\_\_

**IN THE 3 MONTHS PRIOR TO SYMPTOM ONSET:****Y N U**

- Did anyone in the patient's household travel outside the U.S.A. or Canada?  
If yes, where did they travel? \_\_\_\_\_
- Is the patient suspected of being part of a common source outbreak? If yes, type of outbreak:
- Foodborne-associated with infected food handler
  - Foodborne-NOT associated with infected food handler
  - Source not identified
  - Waterborne
- Was the patient employed as a food handler during the **TWO WEEKS** prior to onset of symptoms or while ill?

**VACCINE INFORMATION:****Y N U**

- Has the patient ever received hepatitis a vaccine? If yes:  
Number of doses:  1  2  3 or more  
Year last shot received: \_\_\_\_\_
- Has the patient ever received immune globulin?

**VACCINE RECORD:**

*Note: Vaccine record information cannot be entered in the Investigation. Go to patient's event tab to enter.*

Date administered: \_\_\_\_\_ Age at vaccination: \_\_\_\_\_  
Facility/Organization: \_\_\_\_\_

Vaccine administered: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Lot number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

**PUBLIC HEALTH ISSUES/ACTIONS NOTES****Y N U**

- Disease/Transmission Education Provided  
\*Date: \_\_\_/\_\_\_/\_\_\_
- Exclude individuals in sensitive occupations (food, HCW, child care)
- Restaurant inspection

**Y N U**

- Child care inspection
- Testing of symptomatic contacts
- Patient is lost to follow up

\*Data is being collected as a requirement of Threat Preparedness Grant funding.