

VIRAL HEPATITIS 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

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 ()		
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, please 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"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <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 patient jaundiced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, start date: ___/___/___ Did patient have symptoms other than jaundice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, onset date: ___/___/___ What symptoms? _____	Was the patient hospitalized for hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, admit date: ___/___/___ Facility/Hospital Name: _____ If female: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, due date: ___/___/___ Did patient die from hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, date of death: ___/___/___	Medical Record No. _____
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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"/> Follow-up testing for previous marker of viral hepatitis	Hepatitis B surface antigen (HBsAg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Screening of asymptomatic patient with risk factors	Total antibody to hepatitis B core antigen (total anti-HBc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Screening of asymptomatic patient with no risk factors	IgM antibody to hepatitis B core antigen (IgM anti-HBc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood/organ donor screening	Antibody to hepatitis C virus (anti-HCV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prenatal screening	- anti-HCV signal to cut-off ratio _____			
<input type="checkbox"/> Unknown	Supplemental anti-HCV assay (e.g., RIBA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	HCV RNA (e.g., PCR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____	Antibody to hepatitis D virus (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 appropriate acute hepatitis A or acute hepatitis B and C sections.
 If **NOT** acute hepatitis (check here), please go to **Final Diagnosis** section and complete. Do **NOT** complete the acute hepatitis sections.

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

HOUSEHOLD/CLOSE CONTACTS

Name Relationship to case	Age	Occupation	S.O.S.			Onset date	Comments (include Prophylaxis and Vaccine)
			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"/>	___/___/___	

REMARKS

Educated patient according to B-73 on the following:

Mode of Transmission:

- Fecal-Oral
- Blood to Blood
- Sexual
- Maternal Infant Transmission

Prevention:

- Household Contacts
- Vaccine
- Personal Hygiene
- Immunoglobulin (IG)

Other:

FINAL DIAGNOSIS

- Acute Hepatitis A Chronic Hepatitis B Unable to locate (UTL)
- Acute Hepatitis B Chronic Hepatitis C Could not confirm:
- Acute Hepatitis C False Hepatitis A Explain why? _____
- Acute Hepatitis D False Hepatitis B _____
- Acute Hepatitis E False Hepatitis C

Acute Hepatitis Case Definition:

An acute illness with: discrete onset of symptoms and jaundice or abnormal serum aminotransferase levels

Hepatitis A: IgM anti-HAV positive

Hepatitis B: IgM anti-HBc positive or HBsAg positive and IgM anti-HAV negative if done.

Hepatitis C: Serum aminotransferase (ALT) levels greater than 400 U/L and IgM anti HAV negative, and IgM anti-HBc negative or if not done HBsAg negative, and RIBA positive or PCR for HCV RNA positive or anti-HCV positive with a signal to cut-off ratio >3.8 for the EIA

Investigator's name (print)	Investigator's signature	Date	Telephone number ()
Health District	Supervisor signature	Area Medical Director's signature	

TO BE COMPLETED FOR ACUTE HEPATITIS B AND C

EPIDEMIOLOGIC RISK FACTORS

	Yes	No	Unk
During the 6 months prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B or C virus infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, type of contact: <input type="checkbox"/> Sexual <input type="checkbox"/> Household (Non-sexual) <input type="checkbox"/> Other: _____			
Was the patient EVER treated for a sexually transmitted disease?	<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 exposure details			
Did the patient undergo hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient a resident of a long term facility (e.g. nursing home)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient receive fingersticks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient receive blood or blood products (transfusion)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient receive any IV infusions and/or injections in the outpatient setting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient have dental work or oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient have any diagnostic medical procedure or surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient have other exposure to someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
If Yes, frequency of direct blood contact? <input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent			
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"/>
If Yes, frequency of direct blood contact? <input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent			
Did the patient undergo acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient receive a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, where was the tattooing performed? <input type="checkbox"/> Commercial parlor/shop <input type="checkbox"/> Correctional facility			
Did the patient have any part of their body pierced (other than ear)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, where was the piercing performed? <input type="checkbox"/> Commercial parlor/shop <input type="checkbox"/> Correctional facility <input type="checkbox"/> Other _____			
Did the patient inject drugs not prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient use street drugs but not inject?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unk			
Number of female sex partners <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unk			
Was the patient incarcerated for longer than 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, what type of facility (Check all that apply) <input type="checkbox"/> Prison <input type="checkbox"/> Jail <input type="checkbox"/> Juvenile facility			

EXPOSURE DETAILS Please explain any YES answers in the above section. Please sign your notes.

Suspected Source
