

## HEPATITIS A CONTACT LINE LIST (S2)

For Homeless Persons and/or Illicit Drug-Users



Fax list and updates to ACDC: (213) 202-5999

Investigator name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ District/Program: \_\_\_\_\_  
Date first completed: \_\_/\_\_/\_\_ Updated (if needed): \_\_/\_\_/\_\_

CASE INFORMATION					
vCMR ID#	Case Name (Last, First)	Date of Birth	Onset Date	Infectious Period	
				Onset date minus 14 days	Onset plus 7 days
		__/__/__	__/__/__	__/__/__	__/__/__

PLACE OF EXPOSURE					
Name (Home, Cross Street, Shelter, Facility, etc.)	Address, City, ZIP	Exposure Setting	Outbreak # (if applicable)	Contact Person	Contact Phone
		<input type="checkbox"/> Family or Friend's home <input type="checkbox"/> On Street <input type="checkbox"/> Shelter <input type="checkbox"/> Drug Tx Ctr <input type="checkbox"/> Correctional Fac. <input type="checkbox"/> Psych. Fac. <input type="checkbox"/> Other: _____			

CONTACT INFORMATION								
No	Full name (Last, First)	Age (yr) DOB	Relationship to case	Date of Last Exposure to Case	Similar illness? (Yes/No/Unk) If Yes, Onset date and symptoms.	History of Hepatitis A Vaccine (Yes/No/Unk)	Prophylaxis given? (Yes/No) If Yes, IG or Vacc If No, Reason?	Prophylaxis date
1				__/__/__			<input type="checkbox"/> IG <b>AND/OR</b> <input type="checkbox"/> Vaccine	__/__/__
2				__/__/__			<input type="checkbox"/> IG <b>AND/OR</b> <input type="checkbox"/> Vaccine	__/__/__
3				__/__/__			<input type="checkbox"/> IG <b>AND/OR</b> <input type="checkbox"/> Vaccine	__/__/__
4				__/__/__			<input type="checkbox"/> IG <b>AND/OR</b> <input type="checkbox"/> Vaccine	__/__/__
5				__/__/__			<input type="checkbox"/> IG <b>AND/OR</b> <input type="checkbox"/> Vaccine	__/__/__

Case Name (Last, First) \_\_\_\_\_

vCMR ID# \_\_\_\_\_

Place of Exposure Name \_\_\_\_\_

**CONTACT INFORMATION (Continued)**

No	Full name (Last, First)	Age (yr) DOB	Relationship to case	Date of Last Exposure to Case	Similar illness? (Yes/No/Unk) If Yes, Onset date and symptoms.	History of Hepatitis A Vaccine (Yes/No/Unk)	Prophylaxis given? (Yes/No) If Yes, IG or Vacc If No, Reason?	Prophylaxis date
6				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
7				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
8				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
9				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
10				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
11				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
12				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
13				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__
14				__/__/__			<input type="checkbox"/> IG AND/OR <input type="checkbox"/> Vaccine	__/__/__