

VIRAL HEPATITIS A OR E CASE REPORT



Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
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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 ()		Country of Birth		
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, 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"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Thai <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"/> Exposure to case	Total antibody to hepatitis B core antigen (total anti-HBc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis	IgM antibody to hepatitis B core antigen (IgM anti-HBc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Routine screening of patient (physical exam, MD visit, pre-op)	Hepatitis B surface antigen (HBsAg)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unknown	Antibody to hepatitis B surface antigen (anti-HBs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	HCV antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____	Antibody to hepatitis C virus (anti-HCV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HCV Nucleic Acid Test (NAT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HCV Genotype _____			
	Antibody to hepatitis D virus (IgM 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 remainder of this form. See Page 3 for acute hepatitis A definition.
 If **NOT** acute hepatitis (check here) , please go to **Final Diagnosis** section and complete.

INFECTION TIMELINE

Incubation period: 15-50 days.

Infectious period: Transmission likely to occur 1 to 2 weeks before onset of illness until 7 days after jaundice onset or symptom onset.

Post-exposure prophylaxis: See B-73.

Enter date of onset in onset box
Count backward and forward to determine probable exposure and communicable periods.*

EXPOSURE PERIOD

INFECTIOUS PERIOD



Days from onset:

-50 days

-14 days

ONSET*

+7 days

Calendar dates:

(month/day/year)

____/____/____

____/____/____

____/____/____

____/____/____

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

CLOSE CONTACTS

Name/ Relationship to case	Age	Occupation	S.O.S.			Prior History of Hepatitis A Vaccine	Comments (include Prophylaxis and/or 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"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

EPIDEMIOLOGIC RISK FACTORS

During the infectious period, was the patient employed as a food handler or SOS?..... Yes No Unk

If Yes, Did patient work while ill or in the 2 weeks prior to onset? If Yes, call ACDC immediately..... Yes No Unk

Last day of work: _____ Employer/Situation _____

Address, City _____ Phone () _____

During the exposure period (2-7 weeks prior to onset): If YES, ask patient when and where and record in Remarks section.

If patient was not serologically confirmed, is there an epidemiologic link between the patient and a laboratory-confirmed hepatitis A case? Yes No Unk

Did the patient travel outside of the USA or Canada? Yes No Unk

If Yes, where? Central/South America (including Mexico) Africa Caribbean Middle East
 Asia/South Pacific Australia/New Zealand Other _____

Duration of stay in days _____

Did any of the patient's close contacts travel outside of the USA or Canada? Yes No Unk

Was the patient a close contact of a child or employee in a nursery, day care center or preschool? Yes No Unk

If Yes, was there an identified hepatitis A patient in a nursery, day care center or preschool? Yes No Unk

Was the patient suspected as being part of a common-source outbreak? Yes No Unk

If Yes, specify outbreak # _____

Did the patient eat raw shellfish? Yes No Unk

Did the patient inject drugs not prescribed by a doctor? Yes No Unk

Did the patient use street drugs but not inject? Yes No Unk

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 0 1 2-5 >5 Unk

Number of female sex partners 0 1 2-5 >5 Unk

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

EPIDEMIOLOGIC RISK FACTORS (Continued)

During the exposure period (2-7 weeks prior to onset): If YES, ask patient when and where and record in Remarks section. Yes No Unk

Did the patient know or have contact with anyone with hepatitis A virus infection? (suspected or laboratory-confirmed)

If Yes, was the contact a: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Sexual partner | <input type="checkbox"/> Household member (non-sexual) | <input type="checkbox"/> Drug sharing partner |
| <input type="checkbox"/> Child cared for by this patient | <input type="checkbox"/> Babysitter of this patient | Kind of drug shared? _____ |
| <input type="checkbox"/> Playmate | <input type="checkbox"/> Other _____ | |

FOOD HISTORY (During Exposure Period 2-7 WEEKS PRIOR TO ONSET)

Name (restaurants, bars, food stores, group meals, bakeries, etc.)	Location (Address, City)	Dates Exposed	Foods Eaten

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: | <u>Mode of Transmission:</u> | <u>Prevention:</u> | <u>Other:</u> |
| | <input type="checkbox"/> Fecal-Oral
<input type="checkbox"/> Sexual | <input type="checkbox"/> Household Contacts
<input type="checkbox"/> Vaccine
<input type="checkbox"/> Personal Hygiene
<input type="checkbox"/> Immunoglobulin (IG) | |

FINAL DIAGNOSIS

- | | |
|--|--|
| <input type="checkbox"/> Acute Hepatitis A | <input type="checkbox"/> Unable to locate (UTL) |
| <input type="checkbox"/> False Hepatitis A | <input type="checkbox"/> Could not confirm: Explain why? _____ |
| <input type="checkbox"/> Acute Hepatitis E | |

Acute Hepatitis A - Case Definition:

- 1) An acute illness with discrete onset of symptoms **AND**
- 2) Jaundice **OR** elevated serum aminotransferase levels **AND**
- 3) IgM anti-HAV positive

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