COUNTY OF LOS ANGELES
**Public Health**

Acute Communicable Disease Control
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# VIRAL HEPATITIS B OR C CASE REPORT

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)
☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other: _______________

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, check one: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Thai ☐ Vietnamese ☐ Other: _______________

Occupation or school (give city/zip code)

Homeless? Yes ☐ No ☐

Sensitive Occupation/Situation(S.O.S)? Yes ☐ No ☐

## PRESENT ILLNESS

Diagnosis date: ____________

Was patient jaundiced? ☐ Yes ☐ No ☐ Unknown

If Yes, start date: ____________

Did patient have symptoms other than jaundice?

☐ Yes ☐ No ☐ Unknown If Yes, onset date: ____________

What symptoms? ______________________________________

Was the patient hospitalized for hepatitis?

☐ Yes ☐ No ☐ Unknown If Yes, admit date: ____________

Medical Record No.

Facility/Hospital Name:

If female: Pregnant?

☐ Yes ☐ No ☐ Unknown If Yes, due date: ____________

Did patient die from hepatitis?

☐ Yes ☐ No ☐ Unknown If Yes, date of death: ____________

## VACCINE HISTORY

| | Yes | No | Unk | If Yes, Date dose given. 1st Dose | 2nd Dose | 3rd Dose |
|---|---|---|---|---|---|---|
| hepatitis A vaccine | ☐ | ☐ | ☐ | | | |
| hepatitis B vaccine | ☐ | ☐ | ☐ | | | |

## DIAGNOSTIC TESTS *(Check all tests performed and attach laboratory results.)*

Reason for testing: (Check all that apply)

☐ Symptoms of acute hepatitis
☐ Evaluation of elevated liver enzymes
☐ Exposure to case
☐ Follow-up testing for previous marker of viral hepatitis
☐ Routine screening of patient (physical exam, MD visit, pre-op)
☐ Blood/organ donor screening
☐ Prenatal screening
☐ Unknown
☐ Other

Specify: ________________________________________

| Laboratory results: | Pos | Neg | No Test/Unk |
|---|---|---|---|
| Total antibody to hepatitis A virus (total anti-HAV) ………………….. | ☐ | ☐ | ☐ |
| IgM antibody to hepatitis A virus (IgM anti-HAV) ……………………. | ☐ | ☐ | ☐ |
| Total antibody to hepatitis B core antigen (total anti-HBc) ……….... | ☐ | ☐ | ☐ |
| IgM antibody to hepatitis B core antigen (IgM anti-HBc) …………… | ☐ | ☐ | ☐ |
| Hepatitis B surface antigen (HBsAg) ………………………………….. | ☐ | ☐ | ☐ |
| Antibody to hepatitis B surface antigen (anti-HBs) ………………….. | ☐ | ☐ | ☐ |
| HCV antigen ………………………………………………………………... | ☐ | ☐ | ☐ |
| Antibody to hepatitis C virus (anti-HCV) ………………………………. | ☐ | ☐ | ☐ |
| HCV Nucleic Acid Test (e.g. NAT, PCR) …………………………….. | ☐ | ☐ | ☐ |
| HCV Genotype ________________________________ | | | |
| Antibody to hepatitis D virus (IgM anti-HDV) …………………………. | ☐ | ☐ | ☐ |
| Antibody to hepatitis E virus (IgM anti-HEV) …………………………. | ☐ | ☐ | ☐ |

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 B and C definitions.

If **NOT** acute hepatitis (check here ☐), please go to **Final Diagnosis** section and complete.

Patient name (last, first) ______________________________ Date of Birth ________________ VCMR ID: ____________

## HOUSEHOLD/SEXUAL CONTACTS

| Name/ Relationship to case | Age | Prior history of Hepatitis B Vaccine | | | Hepatitis B Vaccine given | | | Date vaccine given | Comments (include Prophylaxis and/or Vaccine) |
|---|---|---|---|---|---|---|---|---|---|
| | | Yes | No | Unk | Yes | No | Unk | | |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |

## EPIDEMIOLOGIC RISK FACTORS

| | Yes | No | Unk |
|---|---|---|---|
| Was the patient EVER treated for a sexually transmitted disease? | ☐ | ☐ | ☐ |
| Was the patient EVER denied from donating blood due to hepatitis infection? | ☐ | ☐ | ☐ |

**During the 6 months prior to onset of symptoms: If YES, ask patient when and where and record in Remarks section.**

| | Yes | No | Unk |
|---|---|---|---|
| Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B or C virus infection? | ☐ | ☐ | ☐ |
| If Yes, contact type: ☐ Sexual ☐ Household (Non-sexual) ☐ Injection drug use ☐ Occupation ☐ Other:___________ | | | |
| Did the patient undergo hemodialysis? | ☐ | ☐ | ☐ |
| Was the patient a resident of a long term facility (e.g. nursing home)? | ☐ | ☐ | ☐ |
| Did the patient receive fingersticks? | ☐ | ☐ | ☐ |
| Did the patient receive blood or blood products (transfusion)? | ☐ | ☐ | ☐ |
| Did the patient receive any IV infusions and/or injections? | ☐ | ☐ | ☐ |
| Did the patient have prior history of hospitalization? | ☐ | ☐ | ☐ |
| Did the patient have dental work or oral surgery? | ☐ | ☐ | ☐ |
| Did the patient have surgery other than oral surgery? | ☐ | ☐ | ☐ |
| Did the patient have any outpatient medical procedure or surgery (e.g. colonoscopy, endoscopy)? | ☐ | ☐ | ☐ |
| Did the patient have any podiatric procedures? | ☐ | ☐ | ☐ |
| Did the patient donate blood? | ☐ | ☐ | ☐ |
| Date of last blood donation. ______________ Location of last donation. ________________________ | | | |
| Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? | ☐ | ☐ | ☐ |
| Did the patient have other exposure to someone else's blood? | ☐ | ☐ | ☐ |
| Did the patient have a manicure or pedicure? | ☐ | ☐ | ☐ |
| Did the patient undergo acupuncture? | ☐ | ☐ | ☐ |
| Did the patient receive a tattoo? | ☐ | ☐ | ☐ |
| If Yes, where was the tattooing performed? ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other ___________ | | | |
| Did the patient have any part of their body pierced (other than ear)? | ☐ | ☐ | ☐ |
| If Yes, where was the piercing performed? ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other ___________ | | | |
| Did the patient inject drugs not prescribed by a doctor? | ☐ | ☐ | ☐ |
| Did the patient use street drugs but not inject? | ☐ | ☐ | ☐ |

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

| | Yes | No | Unk |
|---|---|---|---|
| Was the patient incarcerated for longer than 24 hours? | ☐ | ☐ | ☐ |

If Yes, what type of facility (Check all that apply) ☐ Prison ☐ Jail ☐ Juvenile facility

Patient name (last, first) ____________________ Date of Birth ____________ VCMR ID: ________

## EPIDEMIOLOGIC RISK FACTORS (Continued)

| **During the 6 months prior to onset of symptoms: If YES, ask patient when and where and record in Remarks section.** | Yes | No | Unk |
|---|---|---|---|
| Was the patient employed in a medical or dental field involving direct contact with human blood? | ☐ | ☐ | ☐ |
| Was the patient employed as a public safety worker (fire fighter, law enforcement/correctional officer) having direct contact with human blood? | ☐ | ☐ | ☐ |
| Indication of recent seroconversion | | | |
| Negative HBsAg result within 6 months prior to HBV diagnosis | ☐ | ☐ | ☐ |
| Negative Anti-HCV result within 12 months prior to HCV diagnosis | ☐ | ☐ | ☐ |

## 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:

Mode of Transmission:
- ☐ Blood to blood
- ☐ Sexual
- ☐ Maternal Infant Transmission

Prevention:
- ☐ Household Contacts
- ☐ Vaccine
- ☐ Personal Hygiene
- ☐ Immunoglobulin (HBIG)

Other:

## FINAL DIAGNOSIS

- ☐ Acute Hepatitis B
- ☐ Acute Hepatitis C:
  - ☐ Confirmed
  - ☐ Probable
- ☐ Acute Hepatitis D
- ☐ Unable to locate (UTL)
- ☐ False Hepatitis B
- ☐ False Hepatitis C
- ☐ False Hepatitis D
- ☐ Chronic Hepatitis B
- ☐ Chronic Hepatitis C
- ☐ Chronic Hepatitis D
- ☐ Could not confirm: Why? ____________

**Acute Hepatitis B or C Case Definition:**

Hepatitis B:
1) An acute illness with discrete onset of symptoms **AND**
2) (Jaundice **OR** abnormal serum aminotransferase (ALT) levels >100 IU/L) **AND**
3) HBsAg positive **AND** IgM anti-HBc positive (if done).

Hepatitis C:

Confirmed
1) (Jaundice **OR** abnormal serum aminotransferase (ALT) levels >200 IU/L **OR** total bilirubin levels ≥ 3.0 mg/dL) **AND**
2) Verified by HCV NAT positive **OR** HCV antigen* positive

Probable
1) (Jaundice **OR** abnormal serum aminotransferase (ALT) levels >200 IU/L **OR** total bilirubin levels ≥ 3.0 mg/dL) **AND**
2) Anti-HCV positive **AND**
3) **NO** report of HCV NAT positive **AND NO** HCV antigen* positive

*When and if a test for HCV antigen(s) is approved by FDA and available.

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


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