Hepatitis A Case Report Form

Connecticut Department of Public Health
Epidemiology and Emerging Infections Program
410 Capitol Avenue, MS# 11EPI
P.O. Box 340308
Hartford, CT 06134-0308
Phone: 860-509-7994, Fax: 860-509-7910

Completed by: _____ **Date of Completion**: ___/___/____

PATIENT INFORMATION

FIRST: _____ **MIDDLE:**_____ **LAST**: _____

STREET: _____ **CITY**: _____ **STATE**: _____ **ZIP**:_____

COUNTY: _____ **PHONE**: _____ **OCCUPATION**: _____

DEMOGRAPHIC INFORMATION

DATE OF BIRTH:____/____/_____ **AGE:** _____ (years) **SEX:** ☐ Male ☐ Female **PLACE OF BIRTH**: ☐ USA ☐ Other_____

RACE: *(check all that apply)*

☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other_____

ETHNICITY: *(check one)* ☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown

CLINICAL AND DIAGNOSTIC DATA

Diagnosis date (specimen collection date): ____/____/_____

Was the patient symptomatic? ☐ Yes ☐ No ☐ Unk

If yes, symptom onset date: ____/____/_____

Fever	☐ Yes	☐ No	☐ Unk
Nausea	☐ Yes	☐ No	☐ Unk
Vomiting	☐ Yes	☐ No	☐ Unk
Loss of appetite	☐ Yes	☐ No	☐ Unk
Abdominal pain	☐ Yes	☐ No	☐ Unk
Dark urine	☐ Yes	☐ No	☐ Unk
Diarrhea	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk
Malaise	☐ Yes	☐ No	☐ Unk
Other	_____		

Was the patient jaundiced? ☐ Yes ☐ No ☐ Unk
If yes, jaundice onset date: ____/____/_____

Did the patient die from hepatitis? ☐ Yes ☐ No ☐ Unk
If yes, date of death: ____/____/_____

Was the patient part of a common-source outbreak? ☐ Yes ☐ No ☐ Unk
If yes, was the outbreak: ☐ Source not identify ☐ Waterborne

☐ Foodborne – associated with an infected food worker (FW)

☐ Foodborne – NOT associated with an infected FW, food vehicle_____

☐ Other, specify _____

REASON FOR TESTING *(check all that apply)*

☐ Year of birth (1945-1965)

☐ Screening of asymptomatic patient with reported risk factors

☐ Screening of asymptomatic patient w/ no risk factors (e.g., patient requested)

☐ Follow-up testing for previous marker of viral hepatitis

☐ Symptoms of acute hepatitis

☐ Blood/organ donor screening

☐ Evaluation of elevated liver enzymes

☐ Prenatal screening

☐ Other, specify: _____

☐ Unknown

Was the patient hospitalized for hepatitis? ☐ Yes ☐ No ☐ Unk
If yes, admitted: ____/____/_____ discharged: ____/____/_____
Hospital: _____

Was the patient pregnant? ☐ Yes ☐ No ☐ Unk
If yes, due date: ____/____/_____

Does the patient have diabetes? ☐ Yes ☐ No ☐ Unk
If yes, diabetes diagnosis date: ____/____/_____

Liver enzyme levels at time of diagnosis

Date ___/___/____ ALT [SGPT] _____Upper limit normal _____

Date ___/___/____ AST [SGOT] ____ Upper limit normal _____

VACCINATION HISTORY

1. Has the patient ever received the hepatitis A vaccine? ☐ Yes ☐ No ☐ Unk

If yes, how many doses? ☐ 1 ☐ ≥2 ☐ Unk In what year was the last dose received? _____

2. Has the patient ever received immune globulin? ☐ Yes ☐ No ☐ Unk If yes, when was the last dose received? _____/_____ (mo/yr)

CDC/CSTE CASE DEFINITION (2012)

Clinical Description

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and either a) jaundice, or b) elevated serum alanine aminotransferase (ALT) or aspartate aminotransferase (AST) levels.

Laboratory Criteria for Diagnosis

Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive

Confirmed Case Classification

A case that meets the clinical case definition and is laboratory confirmed, **OR** A case that meets the clinical case definition and occurs in a person who has an epidemiologic link with a person who has laboratory-confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15-50 days before the onset of symptoms)

During 2 weeks prior to symptom onset (mm/dd/yr): ___/____/____to (mm/dd/yr): ___/____/____or while symptomatic (CONTAGIOUS PERIOD)

1. Was the patient employed as or at a: ☐ Food handler ☐ Healthcare worker ☐ Daycare/Nursery/ or Preschool ☐Group Home

If yes, name of establishment: _____ Address: _____

Date(s) worked**:** ____/____/_____, ____/____/_____, ____/____/_____, ____/____/_____, ____/____/_____, ____/____/_____,____/____/_____

During 2 to 6 weeks prior to onset of symptoms (mm/dd/yr: _____to (mm/dd/yr):_____ (ask the below EXPOSURE questions)

2. Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection? ☐ Yes ☐ No ☐ Unk

If yes, was the contact: Household member (non-sexual) ☐ Yes ☐ No ☐ Unk

Sex partner ☐ Yes ☐ No ☐ Unk

Child cared for by this patient ☐ Yes ☐ No ☐ Unk

Babysitter of this patient ☐ Yes ☐ No ☐ Unk

Playmate ☐ Yes ☐ No ☐ Unk

Other, specify _____ ☐ Yes ☐ No ☐ Unk

3. Was the patient a child or employee in a day care center, nursery or preschool? ☐ Yes ☐ No ☐ Unk

If yes, name of facility _____ Address: _____

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

If yes, name of facility _____ Address: _____

5. If yes to question 2 or 3, was there an identified hepatitis A case in the child care facility? ☐ Yes ☐ No ☐ Unk

If yes, provide details _____

6. Was the patient employed as a health care worker with direct patient contact? ☐ Yes ☐ No ☐ Unk

If yes, name of facility _____ Address: _____

7. Was the patient employed in a medical, dental or other field involving contact with human blood? ☐ Yes ☐ No ☐ Unk

If yes, what was the degree of blood contact: 1. ☐ Frequent (several times a week) 2. ☐ Infrequent

8. Did the patient receive blood or blood products (transfusion)? ☐ Yes ☐ No ☐ Unk

If yes, specify from where and when? Facility: _____ Date(s) ____/____/_____ to ____/____/____

9. Was the patient associated with a dialysis or kidney transplant unit?

If yes, specify 1. ☐ Patient 2. ☐ Employee 3. ☐ Contact of a patient or employee

If yes, from where and when? Facility: _____ Date(s) ____/____/_____ to ____/____/____

10. Did the patient have: ☐ Dental work/oral surgery ☐ Surgery ☐ Tattooing ☐ Acupuncture ☐ Accidental puncture object contaminated w blood?

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

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

13. What is the sexual preference of the patient ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Unknown

Please ask both of the following questions regardless of the patient's gender:

14. How many male sex partners did the patient have? ☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unk

15. How many female sex partners did the patient have? ☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unk

16. Was the patient in contact with a child recently adopted from outside the United States? ☐ Yes ☐ No ☐ Unk

If yes, what was the date the child arrived in US ____/____/_____ what country_____

17. Did the patient travel or live outside of the US or Canada? ☐ Yes ☐ No ☐ Unk

If yes, what country (please select the region and indicate dates of travel below) _____

☐ So./Central America(including Mexico) ☐Africa ☐Caribbean ☐ Middle East ☐Asia/So. Pacific ☐ Australia/ New Zealand ☐ Other _____

Date(s) of travel 1: ____/____/ - ____/____/_____ Date(s) of travel 2: ____/____/ - ____/____/_____ Date(s) of travel 3: ____/____/ - ____/____/_____

Principle reason for travel: ☐ Business ☐ New immigrant ☐ Tourism ☐ Adoption ☐ Visiting relatives ☐ Other _____ ☐ Unk

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During 3 months prior to onset of symptoms (mm/dd/yr): ____/____/____to (mm/dd/yr): ____/____/____ (ask the below question)

18. Did anyone in the patient's household travel outside the US or Canada? ☐ Yes ☐ No ☐ Unk

If yes, what country (please select the region and indicate dates of travel below)_____

☐ So./Central America(including Mexico) ☐Africa ☐Caribbean ☐ Middle East ☐Asia/So. Pacific ☐ Australia/ New Zealand ☐ Other _____

Date(s) of travel 1: ____/____/ - ____/____/_____ Date(s) of travel 2: ____/____/ - ____/____/_____ Date(s) of travel 3: ____/____/ - ____/____/____

Please use this section when the case does not report international travel or report contact with a person with hepatitis A

During 2 to 6 weeks prior to onset of symptoms (mm/dd/yr:___/___/___to (mm/dd/yr: ___/__/___ (ask the below questions)

19. List any restaurants at which the case ate/drank during 2 to 6 weeks prior to onset (Note: If case cannot recall specific meals or restaurant visits, ask which establishments case would likely have visited.)

Name	City	Date(s)	Foods/Drinks Consumed

20. List any grocery stores, markets, bakeries, fruit stands where case purchased foods consumed 2 to 6 weeks prior to onset.

Name	City	Date(s)	Foods/Drinks Consumed

21. Untreated water exposures, e.g., swimming, camping, private well, pools, and hot tubs (names, locations, dates):

Name	City	Date(s)	Foods/Drinks Consumed

22. Did the case consume any of the following foods or drinks during 2 to 6 weeks prior to onset?

Any food from a salad bar ☐ Yes ☐ No ☐ Unk
If yes, where purchased/consumed _____
Specify items consumed _____

Any unpasteurized juice or cider ☐ Yes ☐ No ☐ Unk
If yes, where purchased/consumed _____

Any raw shellfish ☐ Yes ☐ No ☐ Unk
If yes, type/brand, where purchased/consumed_____

Any other seafood ☐ Yes ☐ No ☐ Unk
If yes, type/brand, where purchased/consumed _____
If consumed raw/undercooked, specify _____

Fruit smoothies ☐ Yes ☐ No ☐ Unk
If yes, where purchased/consumed _____
Types/brands of fruits (and fresh or frozen)_____

Strawberries ☐ Yes ☐ No ☐ Unk
If yes, brand and where purchased _____
Were they fresh or frozen? _____

Raspberries ☐ Yes ☐ No ☐ Unk
If yes, brand and where purchased _____
Were they fresh or frozen? _____

Blueberries ☐ Yes ☐ No ☐ Unk
If yes, brand and where purchased _____
Were they fresh or frozen? _____

Mixed berries ☐ Yes ☐ No ☐ Unk
If yes, brand and where purchased _____
Were they fresh or frozen? _____

Pomegranate (seeds or fruit) ☐ Yes ☐ No ☐ Unk
If yes, brand and where purchased _____
Were they fresh or frozen? _____

Green onion/scallion ☐ Yes ☐ No ☐ Unk
If yes, brand and where purchased_____

CASE AND CONTACT MANAGEMENT

Definitions:

"Contact" is generally defined as a person who has had ***close contact*** with a confirmed case during the 2 weeks before and 1 week after onset of jaundice and usually includes:

- household contacts **(H)**
- sexual contacts **(S)**
- other ongoing close personal contact (e.g. regular babysitting) **(O)**
- staff and children in the same child care center **(C)**
- foodhandlers employed in the same establishment **(F)**

HCP = health care provider
PEP = post-exposure prophylaxis

CONTACT ROSTER *Please list all* ***close contacts*** *below and complete at least information in SECTION A.*

SECTION A						SECTION B		
Name	**Age**	**Relation to case**	**Contact Type** (H, S, O, C, F) (if "O", specify)	**Phone Number** *(if not from same household)*	**Referred to HCP for PEP?**	**PEP Received?**	**PEP Type**	**Physician/Clinic Name**
					☐ Yes ☐ No	☐ Yes ☐ No	☐ IG ☐ Vaccine Date ___/___/___	
					☐ Yes ☐ No	☐ Yes ☐ No	☐ IG ☐ Vaccine Date ___/___/___	
					☐ Yes ☐ No	☐ Yes ☐ No	☐ IG ☐ Vaccine Date ___/___/___	
					☐ Yes ☐ No	☐ Yes ☐ No	☐ IG ☐ Vaccine Date ___/___/___	
					☐ Yes ☐ No	☐ Yes ☐ No	☐ IG ☐ Vaccine Date ___/___/___	
					☐ Yes ☐ No	☐ Yes ☐ No	☐ IG ☐ Vaccine Date ___/___/___	

PATIENT EDUCATION

Was education provided regarding nature of disease and preventive measures? ☐ Yes ☐ No

If yes, how was education provided? ☐ Verbally ☐ Sent written material ☐ Other ______________________________