WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Acute Hepatitis A

PATIENT DEMOGRAPHICS

Name: (last, first): ____
Address (mailing): ____
Address (physical): ____
City/State/Zip: ____
Phone (home): ______________ **Phone(work/cell)**: _____________
Alternate contact: ☐ *Parent/Guardian* ☐ *Spouse* ☐ *Other*
Name: _________________________________ *Phone:* __________________

Birth date: __ / __ / ____ **Age**: _____
Sex: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Native HI/Other PI ☐Am. Ind/AK Native ☐Asian ☐ Unk

INVESTIGATION SUMMARY

Investigation Start Date: __/__/____ **Investigator:** ______________________ **Investigator phone:** __________________

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐ Laboratory ☐Hospital ☐ Private Provider ☐ Public Health Agency ☐Other – Specify ______________________________
Reporter Name: ____ Reporter Phone: _______________________
Earliest date reported to LHD: __/__/____ **Earliest date reported to State:** __/__/____

CLINICAL

Primary HCP Name: ____ Primary HCP Phone: _______________________________________

Y N U
☐ ☐ ☐ Patient hospitalized for this illness

If yes, hospital name:_________________________________
Patient Chart #________________(if available)
Admin Date: ___ / ___ / _____ Discharge Date: ___/___/____

Place of Birth: _______________________________________

Reason for testing *(check all that apply)*
☐ Symptoms of acute hepatitis
☐ Screening of asymptomatic patient with reported risk factors
☐ Screening of asymptomatic patient with no risk factor, e.g. patient request
☐ Evaluation of elevated liver enzymes
☐ Follow-up testing for previous marker of viral hepatitis
☐ Blood/Organ donor screening
☐ Unknown
☐ Other, specify _______________________

Y N U
☐ ☐ ☐ Is patient pregnant? If yes, Due Date ________________________
Diagnosis date: ___ / ___ / _____

Clinical Findings

Y N U
☐ ☐ ☐ Is patient symptomatic?
Illness Onset date: ___ /___ /_____
☐ ☐ ☐ Jaundice
Jaundice Onset date: ___ /___ /_____
☐ ☐ ☐ Did the patient die from this illness?
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Abdominal pain/right upper quadrant pain
☐ ☐ ☐ Dark Urine
☐ ☐ ☐ Clay colored stool
☐ ☐ ☐ Anorexia
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ Fever
☐ ☐ ☐ Diarrhea

LABORATORY (Please submit copies of ALL Labs associated with this illness to state health department)

ALT Result________ Upper Limits ______ Date: ___________ AST Result________ Upper Limits ______ Date: ___________

Y N U
☐ ☐ ☐ Total antibody to hepatitis A virus (total anti-HAV)
☐ ☐ ☐ IgM antibody to hepatitis A virus (IgM anti-HAV)
☐ ☐ ☐ Hepatitis B surface antigen (HBsAg)
☐ ☐ ☐ Hepatitis B 'e' antigen (HBeAg)
☐ ☐ ☐ Total antibody to hepatitis B core antigen (Total anti-HBc)
☐ ☐ ☐ IgM antibody to hepatitis B core antigen (IgM anti-HBc)
☐ ☐ ☐ HBV DNA

Y N U
☐ ☐ ☐ Antibody to hepatitis C virus (anti-HCV)
☐ ☐ ☐ anti-HVC signal to cut-off ratio
☐ ☐ ☐ Supplemental anti-HCV assay (e.g. RIBA)
☐ ☐ ☐ HCV RNA (e.g. PCR)
☐ ☐ ☐ Antibody to hepatitis D virus (anti-HDV)
☐ ☐ ☐ Antibody to hepatitis E virus (anti-HEV)

EPIDEMIOLOGIC

Case Status: ☐ Confirmed ☐Not a Case ☐Unknown
Diagnosis: X Hepatitis A, Acute ☐ Hepatitis B, Acute ☐ Hepatitis B, Chronic ☐ Perinatal Hepatitis B infection
☐ Hepatitis C, Acute ☐ Hepatitis C, Chronic (past or present) ☐ Hepatitis Delta ☐ Hepatitis E, Acute

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period

	Exposure period			Onset date
Days from onset	**-50** **(Max Incubation)**	**-14** **(Min Incubation)**		⇩
Calendar dates:	__ / __ / ____	__ / __ / ____	⇦	__ / __ / ____

HEPATITIS A EXPOSURES (based on the above exposure period, unless otherwise specified)

DURING THE **2 – 6 WEEKS** PRIOR TO ONSET OF SYMPTOMS DID/WAS THE PATIENT:

Y N U

☐ ☐ ☐ A contact of a person with confirmed Hepatitis A virus infection? If yes, type of contact
- ☐ Babysitter of this patient
- ☐ Child cared for by this patient
- ☐ Household member (non-sexual)
- ☐ Playmate
- ☐ Other (Specify) :_______________________________

☐ ☐ ☐ A child or employee in a daycare center, nursery or preschool?
☐ ☐ ☐ A household contact of a child or employee in a daycare center nursery or preschool?
☐ ☐ ☐ If yes for either of these, was there an identified Hepatitis A case in the child care facility?

☐ ☐ ☐ incarcerated? Dates:__________
☐ ☐ ☐ in a treatment facility or other institutional stetting?
☐ ☐ ☐ in as homeless shelter or other type of shelter?

☐ ☐ ☐ If yes for these, was there an identified Hepatitis A case in the facility?

ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER:

How many male sex partners did patient have
☐0 ☐1 ☐2 – 5 ☐>5 ☐Unknown

How many female sex partners did patient have
☐0 ☐1 ☐2 – 5 ☐>5 ☐Unknown

Y N U

☐ ☐ ☐ Inject street drugs
☐ ☐ ☐ Use street drugs but not inject
☐ ☐ ☐ Homeless or transient
☐ ☐ ☐ Travel outside the U.S.A. or Canada?
If yes, where did they travel? _________________________

IN THE **3 MONTH**S PRIOR TO SYMPTOM ONSET:

Y N U

☐ ☐ ☐ Did anyone in the patient's household travel outside the U.S.A. or Canada?
If yes, where did they travel? _______________________

☐ ☐ ☐ Is the patient suspected of being part of a common source outbreak? If yes, type of outbreak:
- ☐ Foodborne-associated with infected food handler
- ☐ Foodborne-NOT associated with infected food handler
- ☐ Source not identified
- ☐ Waterborne

☐ ☐ ☐ Was the patient employed as a food handler during the **TWO WEEKS** prior to onset of symptoms or while ill?

VACCINE INFORMATION:

Y N U

☐ ☐ ☐ Has the patient ever received hepatitis a vaccine? If yes:
Number of doses: ☐ 1 ☐ 2 ☐ 3 or more
Year last shot received: ____________

☐ ☐ ☐ Has the patient ever received immune globulin?

VACCINE RECORD:

Note: Vaccine record information cannot be entered in the Investigation. Go to patient's event tab to enter.

Date administered: __________________ Age at vaccination:_____
Facility/Organization: ____________________________________

Vaccine administered: ____________________________________
Manufacturer: ____
Lot number: _________________ Expiration date: ____________

PUBLIC HEALTH ISSUES/ACTIONS NOTES

Y N U

☐ ☐ ☐ Disease/Transmission Education Provided
*Date:___/___/____
☐ ☐ ☐ Exclude individuals in sensitive occupations (food, HCW, child care)
☐ ☐ ☐ Restaurant inspection

Y N U

☐ ☐ ☐ Child care inspection
☐ ☐ ☐ Testing of symptomatic contacts
☐ ☐ ☐ Contacts issued PEP
☐ ☐ ☐ Patient is lost to follow up

*Data is being collected as a requirement of Threat Preparedness Grant funding.