West Virginia Bureau for Public Health
Your Health Your Safety Our Purpose
Department of Health & Human Resources

Hepatitis C, Acute

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
☐ ☐ ☐ Did the patient die from this illness?
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Abdominal pain/right upper quadrant pain
☐ ☐ ☐ Dark Urine
☐ ☐ ☐ Clay colored stool
☐ ☐ ☐ Anorexia
☐ ☐ ☐ Malaise
☐ ☐ ☐ Headache
☐ ☐ ☐ Fever

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-HCV 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 ☐ Probable ☐ Suspect ☐ Not a Case ☐ Unknown

Diagnosis: ☐ Hepatitis A, Acute ☐ Hepatitis B, Acute ☐ Hepatitis B, Chronic ☐ Perinatal Hepatitis B infection
X 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	***-180 (Max Incubation)***	***-14 (Min Incubation)***	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

HEPATITIS C EXPOSURES (based on the above exposure period)

DURING THE **2 WEEKS – 6 MONTHS PRIOR** TO THE ONSET OF SYMPTOMS:

Y N U

☐ ☐ ☐ Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection?
If yes, was the type of contact:

☐ ☐ ☐ Sexual

☐ ☐ ☐ Household (non-sexual)

☐ ☐ ☐ Other: Yes (specify)_____ ◯ No ◯ Unknown

ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER - IN THE **6 MONTHS** BEFORE ONSET:

How many Male sex partners did the patient have?
◯ 0 ◯ 1 ◯ 2-5 ◯ >5 ◯ Unknown

How many Female sex partners did the patient have?
◯ 0 ◯ 1 ◯ 2-5 ◯ >5 ◯ Unknown

☐ ☐ ☐ Was the patient **EVER** treated for a sexually transmitted Disease?
If yes, year of most recent treatment _____

☐ ☐ ☐ Did the patient inject drugs not prescribed by a doctor?

☐ ☐ ☐ Did the patient use street drugs, but not inject?

☐ ☐ ☐ Did the patient undergo hemodialysis?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient have an accidental stick or puncture with a Needle or other object contaminated with blood?
If yes, **see Custom Specific Fields** below

☐ ☐ ☐ Did the patient receive blood or blood products (transfusion)?
Date of transfusion: _____
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient receive any IV infusions and/or injections in the outpatient setting?
If yes, see **Customer Specific Fields** below

☐ ☐ ☐ Did the patient have other exposure to someone else's blood?
Specify other: _____
If yes, see **Custom Specific Fields** below

Y N U

☐ ☐ ☐ Was the patient employed in a medical or dental field involving direct contact with human blood?
If yes, frequency of direct blood contact:
☐ Frequent (several times weekly) ☐ Infrequent

☐ ☐ ☐ Was the patient employed as a public safety worker firefighter, law enforcement or correctional officer having direct contact with human blood?
If yes, frequency of direct blood contact:
☐ Frequent (several times weekly) ☐ Infrequent

☐ ☐ ☐ Did the patient receive a tattoo?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient have any part of their body pierced (other than ear)?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient have dental work or oral surgery?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient have surgery (other than oral surgery)?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Was the patient hospitalized?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Was the patient a resident of a long term care facility?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Was the patient incarcerated for longer than 24 hours?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ During his/her lifetime, was the patient **EVER** incarcerated for longer than 6 months?
If yes, what year was the most recent incarceration?_____
If yes, for how long? _____

☐ ☐ ☐ Did the patient receive a needlestick (e.g. use of insulin pens or fingerstick device to monitor glucose, etc.)?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Did the patient have any outpatient procedure?
If yes, see **Custom Specific Fields** below

☐ ☐ ☐ Was the patient a recipient of a transplanted organ or tissue?
If yes, see **Custom Specific Fields** below

CUSTOM SPECIFIC FIELDS

Exposure Detail 1
If yes to: _____
Specify event _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City _____ State _____
Facility Phone #_____

Exposure Detail 2
If yes to: _____
Specify event _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City _____ State _____
Facility Phone #_____

Exposure Detail 3
If yes to: _____
Specify event _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City _____ State _____
Facility Phone #_____

Exposure Detail 4
If yes to: _____
Specify event _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City _____ State _____
Facility Phone #_____

Exposure Detail 5
If yes to: _____
Specify event _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City _____ State _____
Facility Phone #_____

Exposure Detail 6
If yes to: _____
Specify event _____
Date of Event or exposure _____
Facility/Provider name where event/exposure occurred
_____
City _____ State _____
Facility Phone #_____

PUBLIC HEALTH ISSUES

Y N U

☐ ☐ ☐ Patient has **NO** other hepatitis risk factors, **EXCEPT for a procedure received at a healthcare facility/setting within the incubation period** (*i.e.* possible healthcare assoc. infection).

☐ ☐ ☐ Patient is lost to follow up

☐ ☐ ☐ Other, specify _____

PUBLIC HEALTH ACTIONS

Y N U

☐ ☐ ☐ Investigate as possible healthcare-associated infection (HAI).

☐ ☐ ☐ Determine if there are other patients linked to facility /setting.

☐ ☐ ☐ Provide patient education/counseling. If patient is pregnant, counsel regarding transmission from mother to infant.

☐ ☐ ☐ Offer hepatitis A and/or B vaccine (as necessary).

☐ ☐ ☐ Other, specify _____