Infectious Disease Epidemiology and Outbreak Response Bureau
Maryland Department of Health
201 W. Preston St, 3rd Floor
Baltimore, MD 21201
Phone: (410) 767-6700
Fax: (410) 225-7615

Maryland
DEPARTMENT OF HEALTH

CHRONIC HEPATITIS B, C, AND D CO-INFCTION CASE REPORT FORM

Final Case Status:
☐ CONFIRMED
☐ PROBABLE
☐ NOT A CASE

Investigation ID: _____

Investigator: _____

Last Name: _____ First Name: _____ Middle Name: _____

Alias or Maiden Name: _____

Address: Street: _____ City: _____ Phone: _____ Zip Code: _____

Jurisdiction/County: _____ Investigation Start Date: __ __ / __ __ / __ __ __ __

Source of Report Lab ICP Physician Other: _____ Date of Report: _____ / _____ / _____ MMWR Week: _____

Name of Source: _____ Phone: _____

Reporting Provider: _____ Phone: _____ MMWR Year: _____

DEMOGRAPHIC INFORMATION

RACE: (check all that apply)

❑ Amer Indian or Alaska Native ❑ Black or African American ❑ White

❑ Asian ❑ Native Hawaiian or Pacific Islander ❑ Other Race, specify _____

ETHNICITY:

Hispanic..... ❑

Non-Hispanic ..... ❑

Other/Unknown..... ❑

SEX: Male ❑ Female ❑ Unk ❑

PLACE OF BIRTH: ❑ USA ❑ Other: _____

DATE OF BIRTH: M M / D D / Y Y Y Y

AGE: __ __ __ (years) (00 = <1yr , 999 = Unk)

CLINICAL & DIAGNOSTIC DATA

REASON FOR TESTING: (check all that apply)

❑ Year of birth (1945-1965)

❑ Screening of asymptomatic patient with reported risk factors

❑ Screening of asymptomatic patient with 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

❑ Other: specify: _____

❑ Prenatal screening

❑ Unknown

CLINICAL DATA:

	Yes	No	Unk
• Diagnosis date: M M / D D / Y Y Y Y			
• Was the patient jaundiced?	❑	❑	❑
• Did the patient have other symptoms?	❑	❑	❑
if yes, onset date: M M / D D / Y Y Y Y			
• Hospitalized for hepatitis?	❑	❑	❑
Hospital name and dates: _____			
• Was the patient pregnant?	❑	❑	❑
Due date: M M / D D / Y Y Y Y			
• Did the patient die from hepatitis?	❑	❑	❑
• Date of death: M M / D D / Y Y Y Y			
• Was the patient aware they had hepatitis prior to testing?	❑	❑	❑
• Did the patient have a **negative** hepatitis related test in the **prior 6 months**?	❑	❑	❑
• If applicable, list provider of care for hepatitis: _____			
• Is there evidence of past Hep B or C infection?	❑	❑	❑
• Does the patient have diabetes?	❑	❑	❑

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

	Yes	No	Unk
• ALT (SGPT) Result _____ Collection Date (ALT): __ __ / __ __ / __ __			
• AST (SGOT) Result _____ Collection Date (AST): __ __ / __ __ / __ __			
• Elevated Total Bilirubin Result (>= 3.0mg/dl)?	❑	❑	❑
Collection Date (Total Bilirubin): __ __ / __ __ / __ __			

DIAGNOSIS: (check all that apply)

❑ Hepatitis D Co- or Super- Infection

❑ Chronic HBV infection

❑ Chronic HCV infection (Past or Present)

DIAGNOSTIC TESTS:

	Pos	Neg	Unk
• Total antibody to Hep A virus (total anti-HAV)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• IgM antibody to Hep A virus (IgM anti-HAV)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Hepatitis B surface antigen (HBsAg)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Total antibody to hepatitis B core antigen (total anti-HBc)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Hepatitis B "e" antigen (HBeAg)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• IgM antibody to hepatitis B core antigen (IgM anti-HBc)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Hepatitis B DNA (Hep B NAT)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Antibody to hepatitis C virus (anti-HCV)	❑	❑	❑
Collection Date : __ __ / __ __ / __ __ __ __			
• Hepatitis C virus RNA	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Hepatitis C genotype _____ Collection Date: __ __ / __ __ / __ __			
• Antibody to hepatitis D virus (anti-HDV)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Hepatitis D RNA	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Antibody to hepatitis E virus (IgM anti-HEV)	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			
• Hepatitis E RNA	❑	❑	❑
Collection Date: __ __ / __ __ / __ __ __ __			

Patient History — Chronic Hepatitis B/C and D Co-Infection

Investigation ID: _____

The following questions are provided as a guide for the investigation of lifetime risk factors for HBV/HCV infection. Routine collection of risk factor information for persons who test HBV/HCV positive is not required. However, collection of risk factor information for such persons may provide useful information for the development and evaluation of programs to identify and counsel hepatitis-infected persons.

	Yes	No	Unk
Did the patient receive clotting factor concentrates produced prior to 1987?	❑	❑	❑
Was the patient ever employed in a medical or dental field involving direct contact with human blood?	❑	❑	❑
Was the patient ever on long-term hemodialysis?	❑	❑	❑
Has the patient ever injected drugs not prescribed by a doctor even if only once or a few times?	❑	❑	❑
How many sex partners has the patient had (approximate lifetime)? _____			
Was the patient ever incarcerated?	❑	❑	❑
Was the patient ever treated for a sexually transmitted disease?	❑	❑	❑
Note: The following 2 questions are for hepatitis C only			
Did the patient receive a blood transfusion prior to 1992?	❑	❑	❑
Did the patient receive an organ transplant prior to 1992?	❑	❑	❑

	Yes	No	Unk
Was the patient ever a contact of a person with confirmed or suspect hepatitis?	❑	❑	❑
If yes, type of contact			
• Sexual	❑		
• Household [Non-sexual]	❑		
• Other	❑		
Other contact type _____	❑		

HEPATITIS C TREATMENT:

	Yes	No	Unk
Has the patient received medication for the type of hepatitis being reported?	❑	❑	❑
Has treatment for hepatitis C been completed?	❑	❑	❑
Has the patient achieved SVR? (HCV RNA negative >= 12 weeks AFTER treatment is completed)	❑	❑	❑

COMMENTS

PERSON COMPLETING FORM: _____ **DATE:** ____ / ____ / _____