Infectious Disease Epidemiology and Outbreak Response Bureau
Maryland Department of Health
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Maryland
DEPARTMENT OF HEALTH

HEPATITIS C ACUTE 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:

Diagnosis date: M M / D D / Y Y Y Y	Yes	No	Unk
• 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? Death date: M M / D D / Y Y Y Y	❑	❑	❑
• Was the patient aware they had hepatitis prior to testing?	❑	❑	❑
• If the patient had a **negative** hepatitis related test in the **prior 6 months** document lab name, date, and result type _____			
• If applicable, list provider of care for hepatitis: _____			
• Does the patient have diabetes? Diabetes diagnosis date: M M / D D / Y Y Y Y	❑	❑	❑

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

• ALT (SGPT) Result _____ Collection Date (ALT): __ __ / __ __ / __ __

• AST (SGOT) Result _____ Collection Date (AST): __ __ / __ __ / __ __

	Yes	No	Unk
• Elevated Total Bilirubin (>= 3.0mg/dl)? Collection Date (Total Bilirubin): __ __ / __ __ / __ __	❑	❑	❑

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 — Acute Hepatitis C

Investigation ID: _____

During the **2 weeks – 6 months** prior to onset of symptoms was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection?	Yes	No	Unk
	❑	❑	❑
If yes, type of contact			
Sexual	❑		
Household (non-sexual)	❑		
Other: _____	❑		

During the **2 weeks – 6 months** prior to onset of symptoms **Did the patient:**	Yes	No	Unk
• Undergo hemodialysis?	❑	❑	❑
Specify dates, name, and address of facility _____			
• Receive an organ transplant?	❑	❑	❑
Specify organ type _____			
Name and address of facility _____			
• Receive any IV infusions and/or injections in the outpatient setting	❑	❑	❑
Name and address of facility _____			
• Have an accidental stick or puncture with a needle or other object contaminated with blood?	❑	❑	❑
• Receive blood or blood products [transfusion]	❑	❑	❑
If yes, when? M M / D D / Y Y Y Y			
Name and address of facility _____			
• Have other exposure to someone else's blood	❑	❑	❑
If yes, specify _____			
• Have shared blood sugar kits or devices such as lancets?	❑	❑	❑
• Have employment in a medical or dental field involving direct contact with human blood?	❑	❑	❑
If yes, frequency of direct blood contact? ❑ Frequent (several times weekly) ❑ Infrequent			
• Have employment as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?	❑	❑	❑
If yes, frequency of direct blood contact? ❑ Frequent (several times weekly) ❑ Infrequent			

	Yes	No	Unk
• Did the patient receive a tattoo?	❑	❑	❑
Where was the tattooing performed? (select all that apply)			
❑ commercial parlor/shop			
❑ correctional facility ❑ other _____			
• Did the patient have any part of their body pierced (other than ear)?	❑	❑	❑
Where was the piercing performed? (select all that apply)			
❑ commercial parlor/shop			
❑ correctional facility ❑ other _____			

During the **2 weeks – 6 months** prior to onset of symptoms **Did the patient:**	Yes	No	Unk
• Inject drugs not prescribed by a doctor?	❑	❑	❑
• Use street drugs but not inject?	❑	❑	❑
• What kind of drugs were used? _____			
• Have a history of ETOH abuse?	❑	❑	❑
• Have dental work or oral surgery?	❑	❑	❑
Name and address of facility _____			
• Have surgery (other than oral)?	❑	❑	❑
Name and address of facility _____			
• Have residence in a long term care facility?	❑	❑	❑

	Yes	No	Unk
• Have incarceration for longer than 24 hours?	❑	❑	❑
if yes, what type of facility (check all that apply)			
prison	❑		
jail	❑		
juvenile facility	❑		
• During his/her lifetime, **EVER** incarcerated for longer than 6 months?	❑	❑	❑
if yes, what year was the most recent incarceration? Y Y Y Y			
and for how long? M M M (mos)			

What is the sexual preference of the patient?

❑ Heterosexual ❑ Homosexual
❑ Bisexual ❑ Unknown

Ask both of the following questions regardless of the patient's gender.

In the **6 months** before symptom onset, how many	0	1	2–5	>5	Unk
male sex partners did the patient have?	❑	❑	❑	❑	❑
female sex partners did the patient have?	❑	❑	❑	❑	❑

• Was the patient **EVER** treated for a sexually-transmitted disease?	Yes	No	Unk
	❑	❑	❑
if yes, in what year was the most recent treatment? Y Y Y Y			

COMMENTS

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