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

HEPATITIS C PERINATAL 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)

❑ 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: _____	❑	❑	❑
• Did the patient die from hepatitis?	❑	❑	❑
• Date of death: __ __ / __ __ / __ __ __ __			
• 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): __ __ / __ __ / __ __

• Elevated Total Bilirubin Result

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: __ __ / __ __ / __ __ __ __	❑	❑	❑
• Antibody to hepatitis E virus (IgM anti-HEV)..... Collection Date: __ __ / __ __ / __ __ __ __	❑	❑	❑
• Hepatitis E RNA ..... Collection Date: __ __ / __ __ / __ __ __ __	❑	❑	❑

Perinatal Hepatitis C Virus Infection

Investigation ID:

RACE OF MOTHER:

❑ Amer Ind or Alaska Native ❑ Black or African American ❑ White ❑ Unknown

❑ Asian ❑ Native Hawaiian or Pacific Islander

❑ Other Race, specify: _____

ETHNICITY OF MOTHER:

Hispanic..... ❑

Non-hispanic ..... ❑

Other/Unknown..... ❑

	Yes	No	Unk	
Was **Mother** born outside of United States?.....	❑	❑	❑	If yes, what country? _____
Was the **Mother** confirmed HCV RNA positive prior to or at time of delivery?	❑	❑	❑	
• If no, was the mother confirmed HCV RNA positive after delivery?	❑	❑	❑	**NEDSS Case ID of Mother** _____
Date of earliest HCV+ positive test result.....	M M / D D / Y Y Y Y			

COMMENTS

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