

Maryland Department of Health

Acute Viral Hepatitis Case Report

Acute Viral Hepatitis is a reportable disease in Maryland. The health department investigates cases of acute hepatitis in order to assess disease incidence in Maryland. We have received laboratory results for your patient indicating that they may have acute hepatitis. Please help with our public health surveillance efforts by promptly providing the information requested on this form.

PATIENT NAME: _____ DATE OF BIRTH: ____ / ____ / _____

CAS #

SOURCE OF REPORT: <input type="checkbox"/> Lab <input type="checkbox"/> ICP <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____	DATE OF REPORT: ____ / ____ / _____
NAME OF SOURCE: _____	PHONE: () _____ - _____
PRIMARY PHYSICIAN: _____	PHONE: () _____ - _____

CLINICAL DATA

REPORTING PHYSICIAN'S DIAGNOSIS OF HEPATITIS: A B C D E Other

PLEASE DO NOT REPORT CASES OF CHRONIC HEPATITIS OR CHRONIC CARRIERS!!

REASON FOR TESTING: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Symptoms of acute hepatitis
<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors
<input type="checkbox"/> Screening of asymptomatic patient with no known risk factors
<input type="checkbox"/> Prenatal screening
<input type="checkbox"/> Evaluation of elevated liver enzymes | <input type="checkbox"/> Blood or organ donor screening
<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis
<input type="checkbox"/> Corrections Immunity Study
<input type="checkbox"/> Other: (specify) _____
<input type="checkbox"/> Unknown |
|--|--|

SIGNS/SYMPTOMS OF HEPATITIS
(this episode)

Check all that apply:

- | | | |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Pale stools | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Dark urine | <input type="checkbox"/> Nausea | <input type="checkbox"/> Anorexia (loss of appetite) |

DATE OF FIRST SYMPTOM (ONSET) ____ / ____ / _____

DATE OF DIAGNOSIS ____ / ____ / _____

WAS THE PATIENT JAUNDICED? Yes No

WAS THE PATIENT HOSPITALIZED FOR HEPATITIS? Yes No

DID THE PATIENT DIE FROM HEPATITIS? Yes No

TYPE OF HBV/HCV INFECTION: (Based on your evaluation of this patient, what type of infection does this patient have?)

Hepatitis B

- Newly Acquired (probably infected within the last six months)
- Chronic Infection (probably infected more than 6 months ago, even if first recognized now)
- Carrier
- Resolved
- Perinatal
- Unsure

Hepatitis C

- Newly Acquired (probably infected within the last six months)
- Chronic Infection (probably infected more than 6 months ago, even if first recognized now)
- Resolved
- Unsure

LABORATORY RESULTS

Laboratory Information is essential in characterizing this patient's infection. Please report all of the following test results, or, preferably, include a copy of the patient's laboratory report(s). (Lab reports attached)

LIVER ENZYME LEVELS AROUND TIME OF DIAGNOSIS	RESULT	REFERENCE RANGE	DATE
ALT [SGPT]			
AST [SGOT]			

SEROLOGIC/DIAGNOSTIC TESTS: (check all that apply)	POS	NEG	UNK	DATE
Hepatitis A				
Total antibody to hepatitis A virus [Total anti-HAV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IgM antibody to hepatitis A virus [IgM anti-HAV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B				
Total antibody to hepatitis B core antigen [Total anti-HBc]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IgM antibody to hepatitis B core antigen [IgM anti-HBc]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B surface antibody [HBsAb]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B surface antigen [HBsAg]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B e antibody [HBeAb]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B e antigen [HBeAg]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B DNA: _____				_____
Hepatitis C				
Antibody to hepatitis C virus [anti-HCV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
- anti-HCV signal to cut-off ratio: _____				
Supplemental anti-HCV assay [e.g., RIBA]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HCV RNA [e.g., PCR]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis C Genotype: <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> Other: _____				_____
Hepatitis D				
Antibody to hepatitis D virus [anti-HDV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis E				
Antibody to hepatitis E virus [anti-HEV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

IMMUNIZATION HISTORY

HEPATITIS A	YES	NO	UNK
Has the patient ever received the hepatitis A vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many doses? <input type="checkbox"/> 1 <input type="checkbox"/> 2 or more			
In what year was the last dose received? _____			
Has the patient ever received immune globulin (IG)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was the last IG dose received? _____(mo) / _____(yr)			
HEPATITIS B	YES	NO	UNK
Has the patient ever received the three dose series of hepatitis B vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what year? _____			
AND was the patient tested for antibody within 1-6 months after the last dose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was the antibody test <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown			

RISK ASSESSMENT

HEPATITIS A: DURING THE 2 - 6 WEEKS PRIOR TO ONSET OF SYMPTOMS:

	YES	NO	UNK
1. was the patient a child or employee in a nursery, day care center, or preschool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. was the patient a household contact of a child or employee in a nursery, day care center, or preschool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. was the patient a contact of a confirmed or suspected hepatitis A case?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, type of contact: <input type="checkbox"/> Sexual <input type="checkbox"/> Household (non-sexual) <input type="checkbox"/> Other			
4. was the patient employed as a food handler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. did the patient eat raw shellfish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. was the patient suspected as being part of a common-source foodborne or waterborne outbreak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. did the patient travel outside of the U.S. or Canada?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where: <input type="checkbox"/> So/Central America (including Mexico) <input type="checkbox"/> Africa <input type="checkbox"/> Caribbean <input type="checkbox"/> Middle East			
<input type="checkbox"/> Asia/So.Pacific <input type="checkbox"/> Australia/New Zealand <input type="checkbox"/> Other _____			
Duration of stay: <input type="checkbox"/> 1-3 Days <input type="checkbox"/> 4-7 Days <input type="checkbox"/> More than 7 Days			
8. did the patient inject street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. did the patient use street drugs but not inject?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. how many male sex partners did the patient have? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unknown			
11. how many female sex partners did the patient have? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unknown			

**HEPATITIS B: DURING THE 6 WEEKS TO 6 MONTHS PRIOR TO ONSET OF SYMPTOMS
OR HEPATITIS C: DURING THE 2 WEEKS TO 6 MONTHS PRIOR TO ONSET OF SYMPTOMS:**

	YES	NO	UNK
1. was the patient a contact of a confirmed or suspected acute or chronic hepatitis B or C case?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, type of contact: <input type="checkbox"/> Sexual <input type="checkbox"/> Household (non-sexual) <input type="checkbox"/> Other			
2. was the patient employed in a medical, dental or other field involving contact with human blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, degree of blood contact: <input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent			
3. did the patient receive blood or blood products (transfusion)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify date(s) received: From ___ / ___ / _____ to ___ / ___ / _____			
4. was the patient associated with a dialysis or kidney transplant unit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, type of association: <input type="checkbox"/> Patient <input type="checkbox"/> Employee <input type="checkbox"/> Contact of patient or employee			
5. did the patient use needles for injection of street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. did the patient use street drugs but not inject?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. how many male sex partners did the patient have? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unknown			
8. how many female sex partners did the patient have? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unknown			
9. did the patient have			
dental work or oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tattooing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
an accidental stick or puncture with a needle or other object contaminated with blood? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL NOTES

PERSON COMPLETING FORM: _____ DATE: ___ / ___ / _____

WORK SHEET

FOR USE BY LOCAL HEALTH DEPARTMENTS TO DETERMINE THE PATIENT'S MOST PROBABLE SOURCE OF INFECTION

CASE DEFINITION FOR REPORTING OF ACUTE VIRAL HEPATITIS

Newly acquired illness with: 1) discrete onset of symptoms consistent with acute viral hepatitis, and 2) jaundice or elevated serum aminotransferase levels

Hepatitis A: 1) Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive, or Nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive

Hepatitis B: 1) HBsAg positive, and 2) Immunoglobulin M (IgM) antibody to hepatitis B core antigen (IgM anti-HBc) positive (if done)

Hepatitis C: 1) Positive hepatitis C virus detection test: Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative, or genotype testing), or 2) A positive test indicating presence of hepatitis C viral antigen(s) (HCV antigen) Presumptive laboratory evidence: 3) A positive test for antibodies to hepatitis C virus (anti-HCV)

Hepatitis D: 1) HBsAg or IgM anti-HBc positive, and 2) Anti-HDV positive

Hepatitis E: 1) Anti-HEV positive

Reporting Center/Physician Address and Phone #

If patient was hospitalized for hepatitis, give name of hospital

Lab results of other liver function tests: Bilirubin Alk Phos GGT

FURTHER INFORMATION FOR ADMITTED RISK FACTORS AND SOURCES LISTED ON PREVIOUS PAGE

IF APPLICABLE:

- 1. Name, address, and phone # of child care center
2. Name and address of school, grade, classroom attended
3. Name, address, and phone # of restaurant where food handler worked (Hep A only)
4. Food history of patient for the 2-6 wks prior to onset: (Hep A only)
a. Name and location of restaurants
b. Name and location of food stores
c. Name and location of bakery
d. Group meals attended (e.g. reception, church, meeting, etc.)
e. Location raw shellfish purchased
5. Name, address, and phone # of known hepatitis A or hepatitis B contact
6. Contacts requiring prophylaxis for Hep A or Hep B - list name, age, relationship to case, information about IG, HBIG and Vaccine on separate page
7. If transfused, NOTIFY BLOOD CENTER! Name of blood center
a. Number of units of whole blood, packed RBC or frozen RBC received
b. Specify type of blood product (e.g. albumin, fibrinogen, factor VIII, etc.)
8. IF DONOR, name, address, and phone # of donor or plasmapheresis center
9. Name, address, and phone # of dialysis center
10. Name, address, and phone # of dentist or oral surgeon
11. If other surgery performed, name, address, and phone # of location
12. Name, address, and phone # of acupuncturist or tattoo parlor
13. If patient is currently pregnant, give obstetrician's name, address, and phone # and estimated location of delivery

Comments:

Investigator: Date of interview: