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: _____ / _____ / ________ |
| SOURCE OF REPORT: □ Lab □ ICP □ Physician □ 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)

- □ Symptoms of acute hepatitis
- □ Screening of asymptomatic patient with reported risk factors
- □ Screening of asymptomatic patient with no known risk factors
- □ Prenatal screening
- □ Evaluation of elevated liver enzymes
- □ Blood or organ donor screening
- □ Follow-up testing for previous marker of viral hepatitis
- □ Corrections Immunity Study
- □ Other: (specify) ____________________________
- □ Unknown

**SIGNS/SYMPTOMS OF HEPATITIS**  
*(this episode)*

Check all that apply:

- □ None
- □ Pale stools
- □ Fatigue
- □ Fever
- □ Dark urine
- □ Nausea
- □ Vomiting
- □ Abdominal pain
- □ 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)

<table>
<thead>
<tr>
<th>LIVER ENZYME LEVELS AROUND TIME OF DIAGNOSIS</th>
<th>RESULT</th>
<th>REFERENCE RANGE</th>
<th>DATE</th>
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</thead>
<tbody>
<tr>
<td>ALT [SGPT]</td>
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<tr>
<td>AST [SGOT]</td>
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**SEROLOGIC/DIAGNOSTIC TESTS:** (check all that apply)

**Hepatitis A**
- Total antibody to hepatitis A virus [Total anti-HAV] ................................................................. ☐ ☐ ☐ ______
- IgM antibody to hepatitis A virus [IgM anti-HAV] ................................................................. ☐ ☐ ☐ ______

**Hepatitis B**
- Total antibody to hepatitis B core antigen [Total anti-HBc] ................................................................. ☐ ☐ ☐ ______
- IgM antibody to hepatitis B core antigen [IgM anti-HBc] ................................................................. ☐ ☐ ☐ ______
- Hepatitis B surface antibody [HBsAb] ................................................................................................. ☐ ☐ ☐ ______
- Hepatitis B surface antigen [HBsAg] ................................................................................................. ☐ ☐ ☐ ______
- Hepatitis B e antibody [HBeAb] ........................................................................................................... ☐ ☐ ☐ ______
- Hepatitis B e antigen [HbeAg] .................................................................................................................. ☐ ☐ ☐ ______
- Hepatitis B DNA: __________________

**Hepatitis C**
- 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] ............................................................................................................................. ☐ ☐ ☐ ______
- Hepatitis C Genotype: ☐ 1a ☐ 1b ☐ Other: _____

**Hepatitis D**
- Antibody to hepatitis D virus [anti-HDV] .............................................................................................. ☐ ☐ ☐ ______

**Hepatitis E**
- Antibody to hepatitis E virus [anti-HEV] .............................................................................................. ☐ ☐ ☐ ______

**IMMUNIZATION HISTORY**

**HEPATITIS A**
- Has the patient ever received the hepatitis A vaccine? ................................................................. ☐ ☐ ☐
  - If yes, how many doses? ☐ 1 ☐ 2 or more
  - In what year was the last dose received? __________
- Has the patient ever received immune globulin (IG)? ................................................................. ☐ ☐ ☐
  - If yes, when was the last IG dose received? ______(mo) / ______(yr)

**HEPATITIS B**
- Has the patient ever received the three dose series of hepatitis B vaccine? ......................................... ☐ ☐ ☐
  - If yes, what year? __________
  - AND was the patient tested for antibody within 1-6 months after the last dose? ................................ ☐ ☐ ☐
  - If yes, was the antibody test ☐ Pos ☐ Neg ☐ Unknown
## RISK ASSESSMENT

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

1. was the patient a child or employee in a nursery, day care center, or preschool?  
2. was the patient a household contact of a child or employee in a nursery, day care center, or preschool?  
3. was the patient a contact of a confirmed or suspected hepatitis A case?  
   - If yes, type of contact:  
     - Sexual  
     - Household (non-sexual)  
     - Other

4. was the patient employed as a food handler?  
5. did the patient eat raw shellfish?  
6. was the patient suspected as being part of a common-source foodborne or waterborne outbreak?  
7. did the patient travel outside of the U.S. or Canada?  
   - If yes, where:  
     - So/Central America (including Mexico)  
     - Africa  
     - Caribbean  
     - Middle East  
     - Asia/So.Pacific  
     - Australia/New Zealand  
     - Other
   - Duration of stay:  
     - 1-3 Days  
     - 4-7 Days  
     - More than 7 Days

8. did the patient inject street drugs?  
9. did the patient use street drugs but not inject?  

10. how many male sex partners did the patient have?  
    - 0  
    - 1  
    - 2-5  
    - >5  
    - Unknown

11. how many female sex partners did the patient have?  
    - 0  
    - 1  
    - 2-5  
    - >5  
    - Unknown

### HEPATITIS B: DURING THE 6 WEEKS TO 6 MONTHS PRIOR TO ONSET OF SYMPTOMS

1. was the patient a contact of a confirmed or suspected acute or chronic hepatitis B or C case?  
   - If yes, type of contact:  
     - Sexual  
     - Household (non-sexual)  
     - Other

2. was the patient employed in a medical, dental or other field involving contact with human blood?  
   - If yes, degree of blood contact:  
     - Frequent (several times weekly)  
     - Infrequent

3. did the patient receive blood or blood products (transfusion)?  
   - If yes, specify date(s) received:  

4. was the patient associated with a dialysis or kidney transplant unit?  
   - If yes, type of association:  
     - Patient  
     - Employee  
     - Contact of patient or employee

5. did the patient use needles for injection of street drugs?  
6. did the patient use street drugs but not inject?  

7. how many male sex partners did the patient have?  
    - 0  
    - 1  
    - 2-5  
    - >5  
    - Unknown

8. how many female sex partners did the patient have?  
    - 0  
    - 1  
    - 2-5  
    - >5  
    - Unknown

9. did the patient have  
   - dental work or oral surgery?  
   - other surgery?  
   - acupuncture?  
   - tattooing?  
   - an accidental stick or puncture with a needle or other object contaminated with blood?  

### ADDITIONAL NOTES

PERSON COMPLETING FORM:  
DATE: ___ / ___ / ______

MDH 4601 January 2020
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) Immuno globulin 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 shellfis h 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, 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: _________________________

MDH 4601 January 2020