MARYLAND Department of Health

ACUTE HEPATITIS A CASE REPORT

The following questions should be asked for every case of acute hepatitis A

NEDSS ID: _____ Date of Report _____

Prefix: (Mr. Mrs. Miss Ms. etc)_____Last:_____First:_____Middle:_____

Preferred Name (nickname):_____Maiden:_____

Address: Street:_____

City:_____Phone: (_____)_____–_____Zip Code:_____– _____

State:_____County:_____

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 ❑ Other ❑ Unknown ❑

DATE OF BIRTH:_____/_____/_____

COUNTRY OF BIRTH ❑ USA ❑ Other: _____

AGE _____

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

SIGNS/SYMPTOMS: CHECK ALL THAT APPLY

❑ None ❑ Pale (White/Gray) Stools ❑ Nausea ❑ Abdominal Pain ❑ Anorexia ❑ Other _____

❑ Fatigue ❑ Fever_____°F ❑ Vomiting ❑ Dark Urine ❑ Diarrhea

CLINICAL DATA:

	Yes	No	Unk
Diagnosis Date:_____/_____/_____			
Is patient symptomatic?	❑	❑	❑
If yes, onset date:_____/_____/_____			
At diagnosis, was the patient			
• Jaundiced?	❑	❑	❑
Onset date:_____/_____/_____			
• Hospitalized for hepatitis?	❑	❑	❑
If yes, hospital name: _____			
Admission Date:_____/_____/_____			
Discharge Date:_____/_____/_____			
Was the patient pregnant?	❑	❑	❑
Due date:_____/_____/_____			
Did the patient die from hepatitis A?	❑	❑	❑
• Date of death:_____/_____/_____			

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

• ALT [SGPT] Result_____ Upper limit normal _____

• Date of ALT result:_____/_____/_____

• AST [SGOT] Result_____ Upper limit normal _____

• Date of AST result:_____/_____/_____

• Total Bilirubin Result_____ Upper bilirubin normal _____

• Date of bilirubin result:_____/_____/_____

DIAGNOSTIC TESTS: (SELECT ALL THAT APPLY)

	Pos	Neg	Unk
• Total antibody to hepatitis A virus [total anti-HAV].....	❑	❑	❑
• IgM antibody to hepatitis A virus [IgM anti-HAV].....	❑	❑	❑
• Nucleic Acid Testing for hepatitis A [Hep A NAT].....	❑	❑	❑
-- Genotype Result _____			
• Hepatitis B surface antigen [HBsAg]	❑	❑	❑
• Total antibody to hepatitis B core antigen [total anti-HBc].....	❑	❑	❑
• Hepatitis B "e" antigen [HBeAg]	❑	❑	❑
• IgM antibody to hepatitis B core antigen [IgM anti-HBc]	❑	❑	❑
• Nucleic Acid Testing for hepatitis B [HepBNAT].....	❑	❑	❑
• Antibody to hepatitis C virus [anti-HCV]	❑	❑	❑
– anti-HCV signal to cut-off ratio _____			
• Supplemental anti-HCV assay [e.g., RIBA]	❑	❑	❑
• Antibody to hepatitis D virus [anti-HDV]	❑	❑	❑
• Antibody to hepatitis E virus [IgM anti-HEV].....	❑	❑	❑

	Yes	No	Unk
If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case? ❑		❑	❑

Final Case Classification

❑ Acute hepatitis A ❑ Probable hepatitis A ❑ Not a Case

MMWR Week:_____ MMWR Year: _____

Date case closed:_____/_____/_____

Patient History — Acute Hepatitis A

NEDSS ID:

VACCINATION HISTORY

	Yes	No	Unk	
Has the patient ever received the hepatitis A vaccine?.....	❑	❑	❑	
	1	**≥2**		
• If yes, how many doses?.....	❑	❑		•In what year was the last dose received?....._____(Year)
	Yes	**No**	**Unk**	
Has the patient ever received immune globulin?.....	❑	❑	❑	• If yes, when was the last dose received?....._____/_____(Mo/Year)

During the 2-6 weeks prior to onset of symptoms-	**Yes**	**No**	**Unk**
Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection?	❑	❑	❑
If yes, was the contact (check one)			
•household member(non-sexual)	❑	❑	❑
•sex partner	❑	❑	❑
•child cared for by this patient.....	❑	❑	❑
•babysitter of this patient	❑	❑	❑
•playmate	❑	❑	❑
• other _____			
Did the patient have contact with someone with a similar illness?.....	❑	❑	❑
If yes is checked above:			
What is the name and relationship to the patient? _____			
When did the contact take place?_____			
What is the patient's occupation? _____			
Was the patient			
• a child or employee in a day care center, nursery, or preschool?	❑	❑	❑
If yes, what is the name of the facility? _____			
•a household contact of a child or employee in a day care center, nursery or preschool?.....	❑	❑	❑
If yes, what is the name of the facility? _____			

Please ask the following questions regardless of the patient's gender.

What is the sexual orientatation of the patient?

❑ Heterosexual ❑ Homosexual ❑ Bisexual
❑ Other ❑ Refused ❑ Unknown

In the 2–6 weeks 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?	❑	❑	❑	❑	❑

If the patient had sexual partners, where did the patient meet their partner(s)?

Check all that apply:

❑ Bar ❑ Social Gathering ❑ App ❑ Other _____

Name/location of meeting place(s)? _____

In the 2-6 weeks before symptom onset:	**Yes**	**No**	**Unk**
Did the patient inject drugs not prescribed by a doctor?	❑	❑	❑
If yes, what kind(s)?_____			
Did the patient use street drugs but not inject?	❑	❑	❑
If yes, what kind(s)?_____			

Patient History — Acute Hepatitis A

NEDSS ID:

In the 2-6 weeks before symptom onset:

What type of locations did the patient live in? Check all that apply.

❑ Private Home/Apartment ❑ Motel ❑ Rehab Facility ❑ Other

❑ Hospital ❑ Shelter ❑ Jail/Correctional Facility

Name and address of location(s)? _____

	Yes	No	Unk
Did the patient **travel or live** outside of the U.S.A.	❑	❑	❑

If yes, where? 1) _____ 2) _____

(Country) 3) _____

What was the primary reason for travel? ❑ Business ❑ New Immigrant ❑ Other

❑ Visiting relatives/friends ❑ Adoption ❑ Unknown

❑ Tourism

Did the patient **travel or live** inside of the U.S.A. besides Maryland	❑	❑	❑
In the **3 months** prior to symptom onset did anyone in the patient's household travel outside of the U.S.A.?	❑	❑	❑
Is the patient suspected as being part of a common-source outbreak?	❑	❑	❑

If yes, where? 1) _____ 2) _____

(State) 3) _____

If yes, where? 1) _____ 2) _____

(Country) 3) _____

If yes, what was the outbreak name? _____

If yes, was the outbreak:

Foodborne — associated with an infected food handler	❑	❑	❑
Foodborne — **NOT** associated with an infected food handler	❑	❑	❑
Specify food item _____			
Waterborne	❑	❑	❑
Source not identified	❑	❑	❑
Was the patient employed as a food handler during the **TWO WEEKS** prior to onset of symptoms or while ill?.....	❑	❑	❑

If yes, the facility's name/address? _____

In the 2-6 weeks before symptom onset:

Did the patient

Follow any special or restricted diets?	❑	❑	❑
Please specify: _____			
Eat outside the home?	❑	❑	❑

If yes, fill out the attached food history questionnaire.

Additional Comments

Food History Linelist

List any food/food products consumed <u>OUTSIDE</u> the home in the last 2-6 weeks prior to onset:
(include any carry out, fast food, parties, potlucks, restaurants)

Date (MM/DD/YY)	Food Consumed	Any raw/uncooked food?	Location/Event

Contact Tracing

Name of contact	Age	Gender	Occupation	Relationship to patient	Household contact?	Prophylaxis recommended?	Prophylaxis given?	Date prophylaxis given