



Hepatitis A, acute

County _____

LHJ Use ID _____

Reported to DOH Date ____/____/____

LHJ Classification Confirmed

By: Lab Clinical

Epi Link: _____

Outbreak-related

LHJ Cluster# _____

LHJ Cluster Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____

Reporter (check all that apply) Lab Hospital HCP

Public health agency Other

OK to talk to case? Yes No DK Date of interview ____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact Parent/guardian Spouse Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender F M Other Unk

Ethnicity Hispanic or Latino

Not Hispanic or Latino

Race (check all that apply)

Amer Ind/AK Native Asian

Native HI/other PI Black/Afr Amer

White Other Unk

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

Discrete onset of symptoms

Diarrhea Maximum # of stools in 24 hours: _____

Pale stool, dark urine (jaundice)

Onset date ____/____/____

Abdominal cramps or pain

Nausea

Vomiting

Loss of appetite (anorexia)

Fatigue

Vaccinations

Y N DK NA

Received any doses of hepatitis A vaccine

Number doses in past: _____

Year of last dose: _____

Laboratory

Collection date ____/____/____

Source _____

P = Positive O = Other

N = Negative NT = Not Tested

I = Indeterminate

P N I O NT

Hepatitis A IgM (anti-HAV)

Serum aminotransferase (SGOT [AST] or SGPT [ALT]) elevated above normal

Clinical Findings

Y N DK NA

Complications, specify: _____

NOTES

Hospitalization

Y N DK NA

Hospitalized at least overnight for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

Died from illness Death date ____/____/____

Autopsy Place of death _____

INFECTION TIMELINE

Enter jaundice onset date in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:	Exposure period		Contagious period
	-50	-15	
Calendar dates:	<input type="text"/>	<input type="text"/>	<input type="text"/> * may be longer in children

EXPOSURE (Refer to dates above)

Y N DK NA

Travel out of the state, out of the country, or outside of usual routine
 Out of: County State Country
 Destinations/Dates: _____

Case knows anyone with similar symptoms

Epidemiologic link to a lab confirmed case
 Household (nonsexual) Sexual
 Child care Other: _____

Attends or works in day care setting

Congregate living Type:
 Barracks Corrections Long term care
 Dormitory Boarding school Camp
 Shelter Other: _____

Shellfish or seafood
 County/location collected: _____

Group meal (e.g. potluck, reception)

Food from restaurants
 Restaurant name/Location: _____

Y N DK NA

Drank untreated/unchlorinated water (e.g. surface, well)

Foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
 Specify country: _____

Non-injection street drug use

Injection street drug use
 Injection street drug use type: _____

Any type of sexual contact with others during exposure period
 # female sexual partners: _____
 # male sexual partners: _____

How was this person likely exposed to the disease:
 Food Drinking Water Sexual contact Illicit drugs
 Nonsexual close contact Other Unknown Multiple risk factors

Where did exposure probably occur?
 U.S. but not WA (State: _____)
 In WA (County: _____)
 Not in U.S. (Country/Region: _____)
 Unknown

Exposure details: _____

No risk factors or exposures could be identified

Patient could not be interviewed

PATIENT PROPHYLAXIS / TREATMENT

PUBLIC HEALTH ISSUES

Y N DK NA

Employed as food worker

Non-occupational food handling (e.g. potlucks, receptions) during contagious period

Employed in child care or preschool

Attends child care or preschool

Household member or close contact in sensitive occupation or setting (HCW, child care, food)

Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
 Agency/location: _____
 Specify type of donation: _____

Part of a common source outbreak:
 Infected food worker
 Food not from food worker
 Waterborne Other: _____

Failure of vaccine or postexposure prophylaxis

PUBLIC HEALTH ACTIONS

Notify blood or tissue bank

Prophylaxis of contacts recommended
 Date initiated: ___/___/___
 Number recommended prophylaxis: _____
 Number receiving prophylaxis: _____
 Number completing prophylaxis: _____

Exclude case from sensitive occupations (HCW, food, child care) or situations (child care) until diarrhea ceases

Test symptomatic contacts

Prophylaxis recommended to non-household contacts

Public announcement recommended

Restaurant inspection

Investigate vaccine or postexposure prophylaxis failure

Other, specify: _____

Investigator _____	Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____		Record complete date ___/___/___