



Completed forms may be mailed to: DOH ID PO Box 47838 Olympia WA 98504-7838

LHJ Use ID Reported to DOH Date LHJ Classification Confirmed Probable By: Lab Clinical Epi Link:

Outbreak-related LHJ Cluster # LHJ Cluster Name: DOH Outbreak #

Hepatitis C, chronic

County

Enhanced Surveillance ID (ESID):

REPORT SOURCE

LHJ notification date Investigation start date Reporter name Reporter phone Primary HCP name Primary HCP phone

PATIENT INFORMATION

Name (last, first) Birth date Age Gender Ethnicity Race (check all that apply) Zip code Phone: Occupation/grade Employer/worksite School/child care name

CLINICAL INFORMATION

Initial Diagnosis date: (Date person learned they had hepatitis C. If year only, enter 01/01/YYYY)

CLINICAL

Setting of current testing: Primary care clinic ID/GI/liver clinic OB/GYN clinic ER/UC Hospital Rehab facility Syringe exchange Jail/prison Non-clinical/community site EvalWeb ID: Other:

Reason for testing (check all that apply): Symptoms of hepatitis Screening, asymptomatic with risk factors Prenatal screening Screening, asymptomatic without risk factors Elevated LFTs F/u testing for previous marker of viral hep DOB 1945-1965 Blood/organ donor screening Unknown Other:

Y N DK NA

Pregnant If yes, EDD Delivery hospital:

Diabetes If yes, diagnosis date Ever had a liver biopsy Healthcare provider-diagnosed cirrhosis Ever diagnosed with liver cancer

Hospitalization

Y N DK NA

Hospitalized at least overnight for this illness at dx If yes, hospital name: If yes, admit date Discharge date

Died from illness If yes, death date

Vaccinations

Y N DK NA

Documented immunity to hepatitis A (due to either vaccination or previous infection) Number of doses of HAV vaccine in past: Documented immunity to hepatitis B (due to either vaccination or previous infection) Number of doses of HBV vaccine in past:

LABORATORY

P= Positive N= Negative I= Indeterminate O = Other NT= Not Tested

P N I O NT

Reactive anti-HCV screen (mo/yr) Signal to cut-off ratio (if reported):

HCV RNA qualitative (mo/yr) HCV RNA quantitative (mo/yr) Value: I.U. RNA copies

If no HCV RNA confirmatory testing, primary reason (select one):

Patient lost to follow-up Patient declined Treatment not medically indicated Patient with limited life expectancy Other:

HCV genotyping (mo/yr) Results: 1 2 3 4 5 6 Other: Unk

Liver function tests

(if >1 LFT in past 3 months, report peak value; else report most recent).

P N I O NT

Serum aminotransferase (SGOT [AST] or SGPT [ALT]) elevated above normal for lab ALT (SGPT) Actual value: Date AST (SGOT) Actual value: Date May be acute infection if either is >7 x normal

EXPOSURE (lifetime)

Y N DK NA

- Received clotting factor concentrates before 1987
- Received blood products before 1992
- Received solid organ transplant before 1992
- Organ or tissue transplant recipient, date: ___ / ___ / ___
- Chronic hemodialysis
- Birth mother has history of hepatitis C infection
- Employed in job with potential for exposure to human blood or body fluids
- History of occupational needle stick or splash
- Ever had finger stick/prick blood sugar test

Tattoo recipient

If yes, where obtained (check **all** that apply):

Commercial shop/parlor Correctional facility

Other: _____

Ever had body piercing (not including ear piercing) or acupuncture

If yes, where (check **all** that apply):

Commercial shop/parlor Correctional facility

Other: _____

Born outside US

If yes, country: _____

If yes, number of years in U.S.: _____

Ethnic or cultural community the patient most closely identifies with: _____

Y N DK NA

- Contact to a person with hepatitis (known HCV or type unknown)
If yes, type of contact (check **all** that apply):
 Sexual Household (non-sexual)
 Sharing injection drug equipment
 Other: _____
- Ever had sex with others
(Sex includes vaginal, anal, or oral)
Gender of patient's sex partners
 Male Female Both
Approx. # lifetime sex partners: _____
- Ever treated for a sexually transmitted disease
- Ever injected drugs not prescribed by doctor
If yes, type: _____
- If yes**, ever shared needles/other inj. equip.
- If yes**, ever used needle exchange services
- Patient used injection drugs in past 3 months
- History of incarceration

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

No risk factors or exposures could be identified

NOTES

PUBLIC HEALTH ISSUES

Y N DK NA

- Provider form completed/returned
- Patient interview conducted
 If patient interview not conducted, specify why:
 Lost to f/u Refused Deceased
 Out of jurisdiction Language barrier
 Other: _____

- Patient with health insurance
 If **yes**, type (check **all** that apply):
 Medicare Medicaid VA/Military
 Employer Individual
- Patient with regular health care provider or clinic (routine care, visits <=24 mo. apart)
 If **yes**, specialty of regular health care provider:
 Family Practice Int. Med. OB/GYN Other
 Date last seen (in past 24 months): ___/___/___
 Clinic/provider name: _____

- Patient seen or has appointment for medical management of HCV
 If **yes**, specialty of health care provider:
 PCP Specialist If yes, date: ___/___/___
 If **no**, **primary** reason (select **one**):
 Deceased Incarcerated
 Patient declined, due to financial barriers (e.g., no insurance)
 Patient declined, perceived as unnecessary
 Appropriate provider not known
 Appropriate provider known, inaccessible to patient
 Other: _____
 If **don't know**, **primary** reason (select **one**):
 Lost to f/u Moved
 Referral provided, patient follow-up unknown
 Other: _____

- Patient ever tested for HBV
 Date of last test (mo/yr) ___/___ Result: _____
- Patient ever tested for HIV
 Date of last test (mo/yr) ___/___ Result: _____
- From Patient:** Patient informed/educated about HCV.
 If **yes**, topics included (check **all** that apply):
 HCV test result Preventing transmission
 Need for hepatitis A/B vaccine, if not immune
 Avoidance of liver toxins (e.g., alcohol)
 Harm reduction and needle exchange programs, if IDU
 Treatment options
- Patient aware of Hepatitis Education Project (HEP)
- Patient enrolled in HEP

Y N DK NA

- From Provider:** Patient informed/educated about HCV.
 If **yes**, topics included (check **all** that apply):
 HCV test result Preventing transmission
 Need for HAV/HBV vaccine, if not immune
 Avoidance of liver toxins (e.g., alcohol)
 Harm reduction and needle exchange programs, if IDU
 Treatment options
- Treatment recommended by provider
 If not recommended, specify reason:

- Patient has received treatment
 If **yes**, status of treatment:
 Started Discontinued Completed
 If **recommended but not started**, **primary** reason (select **one**):
 Treatment prescribed, set to begin
 Appropriate provider not known
 Appropriate provider known, inaccessible to patient
 Patient financial barriers (e.g., no insurance)
 Patient perceives as unnecessary
 Patient concerns about safety/adverse effect
 Other: _____

PUBLIC HEALTH ACTIONS

- Recommended confirmatory testing
- Counseled on importance of regular healthcare to monitor liver health
- Counseled on avoidance of liver toxins (e.g., alcohol)
- Recommended hepatitis A vaccination
- Recommended hepatitis B vaccination
- Counseled on measures to avoid transmission
- Counseled not to donate blood products, organs or tissues
- Notified blood or tissue bank (if recent donation)
- Counseled about transmission risk to baby, if pregnant
- Reinforced use of universal precautions, if HCW
- Counseled on harm reduction and places to access clean syringes, if current IDU
- Provided information about HEP (206-723-0311 or www.hepeducation.org)
- Provided patient education materials about HCV
- Provided options for access to health care (e.g. CHAP)
- Provided information on alcohol/substance abuse treatment

Investigator _____ Phone/email: _____

Investigation complete date ___/___/___

Local health jurisdiction _____

Record complete date ___/___/___

Case Name: _____