



Hepatitis C, acute

County _____

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 # _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____
 OK to talk to case? Yes No DK Date of interview ___/___/___

PATIENT INFORMATION

Name (last, first) _____ Birth date ___/___/___ Age _____
 Address _____ Homeless Gender F M Other Unk
 City/State/Zip _____ Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Phone(s)/Email _____ Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

CLINICAL INFORMATION

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

Signs and Symptoms

- Y N DK NA
 Discrete onset of symptoms
 Pale stool, dark urine (jaundice)
 Onset date ___/___/___
 Abdominal cramps or pain
 Nausea
 Vomiting
 Loss of appetite (anorexia)
 Fatigue

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: _____

Predisposing Conditions

- Y N DK NA
 Pregnant
 Estimated delivery date ___/___/___
 OB name, address, phone: _____

Laboratory

Collection date ___/___/___
 Source _____

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

Clinical Findings

- Y N DK NA
 Perinatal case (< 1 year old)
 Complications, specify: _____

P N I O NT

- Hepatitis A IgM (anti-HAV) (if done)**
 Hepatitis B core antigen IgM (anti-HBc) (if done)
 HBsAg
 HCV RNA by nucleic acid testing (qualitative, quantitative, or genotype)
 Results: 1 2 3 4 5
 6 Other _____ Unk
 HCV RIBA (recombinant immunoblot assay)
 Anti-HCV with signal to cut-off predictive of true positive
 Alanine aminotransferase (ALT) > 400 IU/L
 Documented negative antibody result within 6 months prior

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: -180 -14

Calendar dates:

o
n
s
e
t

Contagious period*
1+ weeks prior, to indefinite period after, onset

* Lifelong if chronic infection

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case knows anyone with similar symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with confirmed or suspect hepatitis C case (acute or chronic) <input type="checkbox"/> Casual <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Birth <input type="checkbox"/> Needle use <input type="checkbox"/> Casual contact <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living Type: <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Long term care <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Surgery, other medical procedure, hospitalized</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemodialysis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> IV or injection as outpatient</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood transfusion or blood products (e.g. IG, factor concentrates)) Product: _____ Date of receipt: __/__/__</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Organ or tissue transplant recipient, date: __/__/__</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental work or oral surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in job with potential for exposure to human blood or body fluids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Accidental stick or puncture with a sharps contaminated with blood or body fluids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Had contact with someone else's blood</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Body piercing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tattooing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shared razor, toothbrushes or nail care items</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-injection street drug use</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Injection street drug use, type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any type of sexual contact with others during exposure period # female sexual partners: _____ # male sexual partners: _____ # lifetime total sexual partners: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Received treatment for an STD</p> <p>How was this person likely exposed to the disease:</p> <p><input type="checkbox"/> Sexual contact <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Medical/dental procedure</p> <p><input type="checkbox"/> Nonsexual close contact <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Multiple risk factors</p> <p>Where did exposure probably occur?</p> <p><input type="checkbox"/> U.S. but not WA (State: _____)</p> <p><input type="checkbox"/> In WA (County: _____)</p> <p><input type="checkbox"/> Not in U.S. (Country/Region: _____)</p> <p><input type="checkbox"/> Unknown</p> <p>Exposure details: _____</p> <p><input type="checkbox"/> No risk factors or exposures could be identified</p> <p><input type="checkbox"/> Patient could not be interviewed</p>
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PUBLIC HEALTH ISSUES

Y N DK NA

Employed as health care worker, if yes: Employed in a job with human blood exposure: Several times a week Infrequently No Unknown

Patient in a dialysis or kidney transplant unit

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

PUBLIC HEALTH ACTIONS

Notify blood or tissue bank

Should be counseled on measures to avoid transmission

Recommend hepatitis A vaccination if at risk and susceptible

Recommend hepatitis B vaccination if at risk and susceptible

Other, specify: _____

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