

Hepatitis C

COUNTY

FOR STATE USE ONLY

#

___/___/___ case report

confirmed

___/___/___ interstate

presumptive

suspect

Acute Case

date investigation initiated ___/___/___

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

_____ language spoken _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner

Physician _____

ELR

Name _____

Phone _____ Date ___/___/___
(first report) m d yy

Primary M.D. _____

(if different) Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC
 yes no unknown

DATE OF BIRTH ___/___/___
m d yy

or, if unknown, AGE _____

PLACE OF BIRTH
 USA
 other _____

RACE
 White American Indian or Alaska native
 Black unknown
 Asian refused to answer
 Native Hawaiian or Pacific Islander other _____

Worksites/school/day care center

Occupations/grade

BASIS OF DIAGNOSIS

CLINICAL DATA

DIAGNOSIS DATE ___/___/___
m d yy

Symptomatic? yes no unknown

if yes, ONSET DATE (first s/s) ___/___/___
m d yy

Jaundiced yes no ___/___/___

Hospitalized from hepatitis yes no ___/___/___
admit date

Hospital name: _____

Died from hepatitis yes no
Date of death ___/___/___

Pregnant yes no ___/___/___
due date

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 risk factors (e.g., patient requested)
- Prenatal screening
- Evaluation of elevated liver enzymes
- Blood/organ donor screening
- Followup testing for previous marker of viral hepatitis
- Unknown
- Other _____

LABORATORY TESTS

Lab name: _____

Date of blood draw ___/___/___
m d yy

pos. neg. pending not done

IgM anti-HAV

total anti-HAV

HBsAg

IgM anti-HBc

total anti-HBc

anti-HBs

HBV DNA (PCR)

HBeAg

Anti-HCV

Anti-HCV signal-to-cutoff ratio

RIBA

HCV RNA (PCR)

HCV genotype _____

Other

Has the patient previously tested HBsAg-positive?

yes no unknown

if yes, when? ___/___/___
m d yy

Upper limit normal Date of test
m/d/y

(list reference value from lab slips)

ALT (SGPT) _____

AST (SGOT) _____

Bilirubin _____

other tests (specify)

_____/_____/_____
_____/_____/_____
_____/_____/_____



PATIENT'S NAME >

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

Case education provided? yes no unknown if yes, date ____/____/____

Identify other potential concerns; provide details at right:

recent blood/plasma donation yes no unknown

HCW performing invasive procedures yes no unknown

HOUSEHOLD ROSTER/OTHER CONTACTS

Ask about other potential contacts (sexual, needle-sharing, etc.) within the period of communicability. **no other contacts identified**

Name	Age	Relation to Case	Date Contacted	Located?	Education Provided?	PROPHYLAXIS
_____	_____	_____	____/____/____ <small>m d y</small>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> yes by proxy <input type="checkbox"/> no	Prophylaxis Recommended? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> immune If yes, date recommended: ____/____/____ <small>m d y</small>
Prophylaxis given: <input type="checkbox"/> Referred to HCP <input type="checkbox"/> Vaccine <input type="checkbox"/> None				Date prophylaxis given (if applicable): ____/____/____ <small>m d y</small>		

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Notes

ADMINISTRATION

Acute Hepatitis C April 2008

Case report sent to OHS on ____/____/____
 Completed by _____ Date Completed _____ Phone _____ Investigation sent to OHS on ____/____/____