

HEPATITIS C INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/____ Age: _____ years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death: ___/___/____

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____) - ____ - ____ Cell Phone: (____) - ____ - ____ Work Phone: (____) - ____ - ____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/____ Investigation Status: Open Closed Investigator: _____

REPORTING SOURCE

Date of Report: ___/___/____ Reporting Source: _____

CLINICAL

Physician's Name: _____ Phone Number: (____) - ____ - ____ Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: _____

Admission Date: ___/___/____ Discharge Date: ___/___/____ Duration of Stay _____ day(s)

Place of Birth (Country): _____

Reason for Testing (Select all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Blood/Organ donor screening | <input type="checkbox"/> Evaluation of elevated liver enzymes | <input type="checkbox"/> Follow-up testing (prior viral hepatitis marker) |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Prenatal screening | <input type="checkbox"/> Screening of asymptomatic patient with risk factors |
| <input type="checkbox"/> Symptoms of acute hepatitis | <input type="checkbox"/> Unknown | <input type="checkbox"/> Screening of asymptomatic patient without risk factors |

Was the patient pregnant? No Unknown Yes Due Date: ___/___/____

Diagnosis Date: ___/___/____

Is the patient symptomatic? No Unknown Yes Symptom Onset Date: ___/___/____

Was the patient jaundiced? No Unknown Yes

Did the patient die from this illness? No Unknown Yes 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: ___/___/____

Diagnostic Tests:

- | | | | |
|--|--|---|--|
| Total Ab [†] to hepatitis A virus (tot Ab-HAV): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | Ab to hepatitis C virus (Ab-HCV): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk |
| IgM Ab to hepatitis A virus (IgM Ab-HAV): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | Ab-HCV signal to cut-off ratio: | _____ |
| Hepatitis B surface Ag [‡] (HBsAg): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | Supplemental Ab-HCV assay (e.g., RIBA): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk |
| Hepatitis B "e" Ag (HBeAg): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | Hepatitis C virus RNA (e.g., PCR): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk |
| Total Ab to hepatitis B core antigen (tot Ab-HBc): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | Ab to hepatitis D virus (Ab-HDV): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk |
| IgM Ab to hepatitis B core antigen (IgM Ab-HBc): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | Ab to hepatitis E virus (Abi-HEV): | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk |
| Hepatitis B virus DNA: | <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> Unk | | |

[†]Ab=Antibody, [‡]Ag = Antigen

EPIDEMIOLOGIC

Case Status: Confirmed Not a Case Probable Suspect Unknown MMWR Week: _____ MMWR Year: _____

Diagnosis: Hepatitis A, acute Hepatitis B viral infection, perinatal Hepatitis B virus infection, chronic
 Hepatitis B, acute Hepatitis C Virus infection, chronic or resolved Hepatitis C, acute
 Hepatitis Delta co- or super-infection, acute Hepatitis E, acute Hepatitis non-ABC, acute

ADMINISTRATIVE

General Comments: _____

PHA4 SUPERVISOR REVIEW

Date Due: ___/___/____ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)

Date investigation ready for supervisor review: ___/___/____ Reviewed (Not a case) Yes

Review comments (completed by supervisor): _____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: ___/___/____ 2nd Attempt: ___/___/____ 3rd Attempt: ___/___/____

Patient Contact Date(s):

1st Attempt: ___/___/____ Time: _____ AM PM 2nd Attempt: ___/___/____ Time: _____ AM PM

3rd Attempt: ___/___/____ Time: _____ AM PM

Regular Letter Mailed: ___/___/____ Certified Letter Mailed: ___/___/____

Was clinical information obtained from the physician or patient? Yes No

IF NO CLINICAL INFORMATION AVAILABLE OR CHRONIC CASE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

SIGNS & SYMPTOMS

Fever: No Unknown Yes Highest Temp: _____ °F Nausea: No Unknown Yes

Headache: No Unknown Yes Vomiting: No Unknown Yes

Malaise (unexplained tiredness): No Unknown Yes Diarrhea: No Unknown Yes

Anorexia (loss of appetite): No Unknown Yes Abdominal Pain: No Unknown Yes

MEDICAL HISTORY

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms, was the patient:

A contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection? No Unknown Yes

If yes, type of contact (Select all that apply):

Babysitter of this patient Child cared for by this patient Household member (non-sexual)
 Other (specify) _____ Playmate Sex partner Unknown

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms, did the patient:

Undergo hemodialysis? No Unknown Yes

Have an accidental stick or puncture with a needle or other object contaminated with blood? No Unknown Yes

Receive blood or blood products (transfusion)? No Unknown Yes

If yes, date of transfusion: ___/___/____

Receive any IV infusions and/or injections in the outpatient setting? No Unknown Yes

Have other exposure to someone else's blood? No Unknown Yes

If yes, specify other blood exposure: _____

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms:

Was the patient employed in a medical or dental field involving direct contact with human blood? No Unknown Yes

If yes, frequency of direct blood contact? Frequent (several times a week) Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement, correctional officer) in direct contact with human blood?
No Unknown Yes

If yes, frequency of direct blood contact? Frequent (several times a week) Infrequent

Did the patient receive a tattoo? No Unknown Yes

If yes, where was the tattooing performed (select all that apply)?

Commercial parlor/shop Correctional facility Other (specify) _____ Unknown

Did the patient have any part of their body pierced (other than ear)? No Unknown Yes

If yes, where was the piercing performed (select all that apply)?

Commercial parlor/shop Correctional facility Other (specify) _____ Unknown

Did the patient have dental work or oral surgery? No Unknown Yes

Did the patient have surgery (other than oral surgery)? No Unknown Yes

Was the patient hospitalized? No Unknown Yes

Was the patient a resident of a long term care facility? No Unknown Yes

Was the patient incarcerated for more than 24 hours? No Unknown Yes Type of facility (select all): Jail Juvenile facility Prison

During the 2 WEEKS to 6 MONTHS prior to onset of symptoms, did the patient:

Inject drugs not prescribed by a doctor? No Unknown Yes Use street drugs, but not inject? No Unknown Yes

INVESTIGATOR: ASK BOTH OF THE FOLLOWING QUESTIONS REGARDLESS OF THE PATIENT'S GENDER

In the 6 MONTHS before symptom onset, how many:

Male sex partners did the patient have: 0 1 2-5 >5 Unknown

Female sex partners did the patient have: 0 1 2-5 >5 Unknown

During his or her lifetime, was the patient EVER:

Treated for a sexually-transmitted disease? No Unknown Yes If yes, year of most recent treatment: _____

Was the patient incarcerated for longer than 6 months? No Unknown Yes

If yes, year of most recent incarceration: _____ If yes, length of most recent incarceration: _____

During the 2 WEEKS to 6 MONTHS prior to illness:

If yes to dental work or oral surgery, name of dentist or oral surgeon: _____

Address: _____ City: _____ Phone: (____) - ____ - _____