HEPATITIS E INVESTIGATION FORM

PERSON PROVIDING INFORMATION

Name of Person Being Interviewed: _____ Relationship to Patient: _____ Preferred Language: _____

If patient is less than 18 years old, provide parent/proxy's name: _____

Has the patient or patient's proxy been notified by the reporter of this diagnosis or lab result? ☐ No ☐ Unknown ☐ Yes

BASIC DEMOGRAPHIC INFORMATION

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

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Marital Status: ☐ Married ☐ Single, never married ☐ Widowed ☐ Annulled
☐ Domestic partner ☐ Interlocutory ☐ Legally separated ☐ Divorced
☐ Polygamous ☐ Refused to answer ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Did the patient die from this illness? ☐ No ☐ Unknown ☐ Yes

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____

County:_____ Country of birth:_____

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

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

Primary Occupation: _____ Industry:_____

Name and location of employer: _____
_____
_____

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed
Investigator:_____

CONTROL MEASURES

Date ADPH investigator provided patient, or patient representative, with control measures: __ __ / __ __ /__ __ __ __

Education of Case/Contacts: ☐ No ☐ Yes ☐ Not applicable

Exclusion precautions for child care and food handlers provided: ☐ No ☐ Yes ☐ Not applicable

If control measures were not provided, explain: ☐ No ☐ Yes ☐ Not applicable
_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL INFORMATION

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

Was patient hospitalized for this illness? ☐ No ☐ Unknown ☐ Yes

If yes, Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __

Was there a second hospitalization? ☐ No ☐ Unknown ☐ Yes If yes, second admission date: __ __ / __ __ /__ __ __ __

SIGNS AND SYMPTOMS

Was patient symptomatic? ☐ Yes ☐ No ☐ Unknown _____ Illness Onset Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ Age Units: _____ Illness Duration: _____ ☐ months ☐ weeks ☐ days ☐ unknown

Did the patient have: Jaundice?: ☐ Yes ☐ No ☐ Unknown Abdominal Pain?: ☐ Yes ☐ No ☐ Unknown

Fever?: ☐ Yes ☐ No ☐ Unknown Headache?: ☐ Yes ☐ No ☐ Unknown

Nausea?: ☐ Yes ☐ No ☐ Unknown Vomiting?: ☐ Yes ☐ No ☐ Unknown

Joint paint?: ☐ Yes ☐ No ☐ Unknown Dark-colored urine? ☐ Yes ☐ No ☐ Unknown

Diarrhea? ☐ Yes ☐ No ☐ Unknown

CONDITION

Did the patient have any of the following underlying conditions?

☐ CSF leak
☐ Alcohol abuse
☐ Burns
☐ Cirrhosis/liver failure
☐ Deaf/profound hearing loss
☐ Gastric surgery (type): _____
☐ Immunodeficiency (type): _____
☐ Leukemia
☐ None
☐ Other malignancy (type): _____
☐ Peptic ulcer
☐ Splenectomy/asplenia
☐ Hodgkin's disease
☐ Asthma
☐ Cerebral vascular accident (CVA) stroke
☐ Cochlear implant
☐ Diabetes mellitus (insulin): ☐No ☐Unk ☐Yes
☐ Heart failure
☐ Immunoglobulin deficiency
☐ Multiple myeloma
☐ Organ transplant (organ): _____
☐ Other prior illness (type): _____
☐ Renal failure/dialysis
☐ Systemic lupus erythematosus (SLE)
☐ IVDU
☐ Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐ Chronic GI illness/diarrhea
☐ Current smoker
☐ Emphysema/COPD
☐ Hematologic disease (type): _____
☐ Immunosuppressive therapy (steroids, chemotherapy)
☐ Nephrotic Syndrome
☐ Other liver disease (type): _____
☐ Other renal disease (type): _____
☐ Sickle cell anemia
☐ Unknown

Is the patient pregnant? ☐ No ☐ Unknown ☐ Yes If yes, due date: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes

Does the patient attend a day care center? ☐ No ☐ Unknown ☐ Yes

Does the patient work at a day care center? ☐ No ☐ Unknown ☐ Yes

Does the patient live with a day care center attendee? ☐ No ☐ Unknown ☐ Yes

If yes to any of the above, name of day care center: _____

If yes to any of the above, was there an identified hepatitis case in the facility? ☐ No ☐ Unknown ☐ Yes

What type of day care facility?: ☐ Adult day health care ☐ Adult day social care ☐ Child care provided by friend/relative/neighbor ☐ Child care center ☐ In-home care giver ☐ Alzheimer's specific day care

Is food prepared at this facility? ☐ No ☐ Unknown ☐ Yes Does this facility care for diapered persons? ☐ No ☐ Unknown ☐ Yes

Is this patient a food handler? ☐ No ☐ Unknown ☐ Yes If yes, where? _____

Did the patient work as a food handler after onset of illness? ☐ No ☐ Unknown ☐ Yes

What was the last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Related Case(s) Details

Does the patient know of any similarly ill persons? ☐ No ☐ Unknown ☐ Yes

If yes, did the health department collect information about other similarly ill persons and investigate?: ☐ No ☐ Unknown ☐ Yes

Are the other cases related to this one? ☐ No, sporadic ☐ Unknown ☐ Yes, household ☐ Yes, not household ☐ Yes, outbreak

Note: Please enter name and Case ID of epi-linked case(s) in the General Comments

Is this case part of an outbreak? ☐ No ☐ Unknown ☐ Yes If yes, outbreak name:_____

Disease Acquisition

Where was the disease acquired?: ☐ Imported, Undetermined Source State/County ☐ Indigenous ☐ International ☐ In State, Out of Jurisdiction ☐ Out of State ☐ Unknown

Imported Country: _____ Imported State: _____ Imported City: _____

Imported County: _____

Exposure Location

Country of Exposure: _____ State/Province of Exposure: _____ City of Exposure: _____

County of Exposure: _____

Binational Reporting Criteria: ☐ Exposure to suspected product from Canada or Mexico ☐ Has contacts in or from Canada or Mexico ☐ Potentially exposed by a resident in Canada or Mexico ☐ Resident of Canada or Mexico ☐ Other situations that may require coordination of response or binational notification ☐ Potentially exposed while in Canada or Mexico

CASE STATUS

Transmission Mode: ☐ Foodborne ☐ Waterborne ☐ Blood borne ☐ Sexually Transmitted ☐ Indeterminate

Case Status: ☐ Confirmed ☐ Not a Case MMWR Week: _____ MMWR Year:_____

CLINICAL DATA

Reason for Testing *(Select all that apply)*:

☐ Blood/Organ donor screening ☐ Evaluation of elevated liver enzymes ☐ Follow-up testing (prior viral hepatitis marker)

☐ Other (specify): _____ ☐ Prenatal screening ☐ Symptoms of acute hepatitis

☐ Screening of asymptomatic patient without risk factors ☐ Unknown

☐ Screening of asymptomatic patient with risk factors

Clinical Data

Was the patient aware s/he had hepatitis prior to lab testing?: ☐ Yes ☐ No ☐ Unknown

Does the patient have a provider of care for hepatitis?: ☐ Yes ☐ No ☐ Unknown

Does the patient have diabetes?: ☐ Yes ☐ No ☐ Unknown

If yes, Diabetes Diagnosis Date: __ __ / __ __ /__ __ __ __ On Insulin: ☐ Yes ☐ No ☐ Unknown

Liver Enzyme Levels at Time of Diagnosis

Collection Date (ALT): __ __ / __ __ /__ __ __ __ ALT (SGPT) Result: _____ Upper Limit Normal: _____

Collection Date (AST): __ __ / __ __ /__ __ __ __ AST (SGOT) Result: _____ Upper Limit Normal: _____

Diagnostic Tests

Collection Date (Total Ab†): __ __ / __ __ /__ __ __ __ Total Ab† to hepatitis E virus (total anti-HEV): ☐ Pos ☐ Neg ☐Unknown

Collection Date (IgM anti-HEV): __ __ / __ __ /__ __ __ __ IgM Ab to hepatitis E virus (IgM anti-HEV) :☐ Pos ☐ Neg ☐Unknown

Collection Date (HEV RNA): __ __ / __ __ /__ __ __ __ HEV RNA :☐ Pos ☐ Neg ☐Unknown

†*Ab=Antibody*

DISEASE-SPECIFIC EXPOSURES (15-64 Days Prior to Onset)

Prior to onset, was patient a contact of a person with confirmed or suspected hepatitis infection? ☐ No ☐ Unknown ☐ Yes

Water Exposures

What is the source of tap water at home? ☐ Do not use tap water ☐ Municipal, city, or county ☐ Other_____

☐ Private well ☐ Unknown

If "Private Well", how was home well water treated?

☐ Both filtered and disinfected ☐ Disinfected ☐ Filtered ☐ Neither filtered nor disinfected ☐ Unknown

What is the source of tap water at school/work? ☐ Do not use tap water ☐ Municipal, city, or county ☐ Other_____

☐ Private well ☐ Unknown

If "Private Well", how was school/work well water treated?

☐ Both filtered and disinfected ☐ Disinfected ☐ Filtered ☐ Neither filtered nor disinfected ☐ Unknown

Did the patient drink untreated water prior to onset of illness (e.g., from a river while camping)? ☐ No ☐ Unknown ☐ Yes

Animal Contact

Did the patient come into contact with an animal prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

If yes, select type of animal: ☐ Cat ☐ Cattle ☐ Chicken ☐ Dog ☐ Goats ☐ Lizard ☐ Poultry ☐ Rodent ☐ Sheep ☐ Swine ☐ Turtle ☐Unknown ☐ Other, specify:_____

Type of Animal contact: ☐ Avocational ☐ Occupational ☐ Recreational ☐ Unknown ☐ Other, specify:_____

Name or location of animal contact: _____

Were any of these animals recently acquired? ☐ No ☐ Unknown ☐ Yes

Food Consumption

Did the patient consume raw or undercooked meat (or meat products)? ☐ No ☐ Unknown ☐ Yes
Did the patient consume raw or undercooked shellfish? ☐ No ☐ Unknown ☐ Yes
Did the patient consume raw vegetables? ☐ No ☐ Unknown ☐ Yes

Blood Products

Did the patient receive blood or blood products (transfusion)? ☐ No ☐ Unknown ☐ Yes

Travel

Did the patient travel prior to onset of illness? ☐ No ☐ Unknown ☐ Yes

What was the purpose of travel? ☐ Business ☐ Migration (immigration to US) ☐ Tourism ☐ Visiting relatives/friends

☐ Other _____

Please specify the destination(s):

Destination 1 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train

Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train

Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐ Domestic State/Territory: _____ ☐ International Country: _____

Mode of Travel: ☐ Airplane ☐ Bus ☐ Car ☐ Cruise ship ☐ Train

Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here:

_____

_____

HEPATITIS TREATMENT

Has the patient received medication for the type of hepatitis being reported? ☐ No ☐ Unknown ☐ Yes

GENERAL COMMENTS

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):_____