



# ACUTE HEPATITIS B OR C CASE REPORT

Mail to: California Dept. of Public Health  
 Immunization Branch  
 850 Marina Bay Parkway  
 Building P, 2<sup>nd</sup> Floor, MS 7313  
 Richmond, CA 94804-6403  
 OR Fax to: (510) 620-3949

## CASE IDENTIFICATION AND DEMOGRAPHICS

<b>PATIENT'S NAME</b> Last First Middle initial		
<b>DOB</b> (month/day/year) / /	<b>AGE</b> (enter age and check one) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	<b>DATE OF REPORT</b> / /
<b>ADDRESS NUMBER &amp; STREET</b>		<b>CITY/TOWN</b>
<b>COUNTY</b>		<b>STATE</b>
<b>COUNTRY OF BIRTH</b> <input type="checkbox"/> USA <input type="checkbox"/> OTHER: _____		<b>ZIP CODE</b>
<b>HOME PHONE</b> ( )		<b>OTHER PHONE</b> (specify) ( )
<b>GENDER</b> <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<b>PATIENT'S OCCUPATION</b> <input type="checkbox"/> Hospital/Medical/Dental <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Other: _____ <input type="checkbox"/> Public safety (e.g. law enforcement) <input type="checkbox"/> Correctional facility <input type="checkbox"/> Unknown	
<b>PREGNANT?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>ETHNICITY</b> (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown	<b>RACE</b> (check all that apply) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian: Please specify: _____ <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> White <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander: Please specify: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Other Pacific Islander: _____	
<b>REASONS FOR TESTING</b> (check all that apply) <input type="checkbox"/> Symptoms of acute hepatitis <input type="checkbox"/> Prenatal screening <input type="checkbox"/> Evaluation of liver enzymes <input type="checkbox"/> Unknown <input type="checkbox"/> Exposure to case <input type="checkbox"/> Other: _____	<b>PHYSICIAN NAME</b>	<b>CMR ID</b>
	<b>PHYSICIAN PHONE</b> ( )	<b>CDPH ID</b>

## CLINICAL AND DIAGNOSTIC DATA

<b>SYMPTOMATIC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>If asymptomatic, report as probable chronic hepatitis</i>	<b>SYMPTOMS</b> (check all) <input type="checkbox"/> Jaundice <input type="checkbox"/> Anorexia <input type="checkbox"/> Clay stools <input type="checkbox"/> Dark urine <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other	<b>DIED OF HEPATITIS?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>IF YES, DATE OF DEATH</b> / /	<b>ONSET OF SYMPTOMS</b> / / <b>DIAGNOSIS DATE</b> (test date) / /																																																																											
<b>HOSPITALIZED?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>HOSPITAL NAME</b>	<b>ADMIT DATE</b> / /	<b>DISCHARGE DATE</b> / /																																																																											
<b>HEPATITIS B VACCINE HISTORY</b> Date unknown Vaccine Type <input type="checkbox"/> Dose #1 Date / / <input type="checkbox"/> _____ <input type="checkbox"/> Dose #2 Date / / <input type="checkbox"/> _____ <input type="checkbox"/> Dose #3 Date / / <input type="checkbox"/> _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown If ≤18 years, why not vaccinated? _____ Tested for anti-HBs within 1-2 months after the last dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was serum anti-HBs ≥ 10mIU/ml? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>VIRAL HEPATITIS DIAGNOSTIC TESTS</b> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Positive</th> <th>Negative</th> <th>Unknown</th> <th>Month/Day/Year</th> </tr> </thead> <tbody> <tr> <td>Anti-HCV*</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>Signal to cut-off ratio</td> <td>_____</td> <td>Predictive of a true positive?*</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>HCV RNA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>HCV RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>HCV Genotype</td> <td colspan="3">_____</td> <td></td> </tr> <tr> <td>IgM anti-HAV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>anti-HAV total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>IgM anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>Anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>Anti-HBc total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>Anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> <tr> <td>Other</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>/ /</td> </tr> </tbody> </table>			Positive	Negative	Unknown	Month/Day/Year	Anti-HCV*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	Signal to cut-off ratio	_____	Predictive of a true positive?*	<input type="checkbox"/> Yes <input type="checkbox"/> No		HCV RNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	HCV RIBA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	HCV Genotype	_____				IgM anti-HAV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	anti-HAV total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	IgM anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	Anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	Anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	Anti-HDV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	anti-HEV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
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<b>LIVER ENZYME LEVELS AT DIAGNOSIS</b> ALT [SGPT] Result _____ / / AST [SGOT] Result _____ / / Bilirubin Result _____ / /																																																																														

<b>DIAGNOSIS</b>		
<input type="checkbox"/> <b>CONFIRMED ACUTE HEPATITIS B:</b> Acute illness with discrete symptom onset and at least one item from columns I, II, and III (if done)		
I	II	III (if done)
-Jaundice -ALT >200IU/L	-IgM anti-HBc positive -HBsAg positive	-IgM anti-HAV negative
<input type="checkbox"/> <b>CONFIRMED ACUTE HEPATITIS C:</b> Acute illness with discrete symptom onset and at least one item from columns I, II, and III		
I	II	III
-Jaundice -Dark urine -ALT >400IU/L	-anti-HCV screening-test-positive with signal to cut-off ratio predictive of true positive* -HCV RIBA positive -NAT for HCV RNA positive (including genotype)	-IgM anti-HAV negative -IgM anti-HBc negative

\*See <http://www.cdc.gov/hepatitis/HCV/LabTesting.htm#section1> for information on anti-HCV assays and signal to cut-off ratios

**INCUBATION PERIOD****Hepatitis B:** range 45 to 160 days, average 90 days.**Hepatitis C:** range 2 weeks to 6 months, average 6-7 weeks.**RISK FACTOR INFORMATION (list details below, including dates, locations, types of procedures, etc.)**

During Incubation period did patient have: (if 'Yes' list details below)	Yes	No	Unknown
International Travel Country _____ Dates of travel _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact of a confirmed or suspected case of hepatitis B/C Type of contact: <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accidental stick/puncture with an object contaminated with blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other exposure to someone's blood (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receipt of blood or blood products (transfusion)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior Hospitalization Provide dates and name(s) of hospital below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient procedure (i.e., colonoscopy, endoscopy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IM injections or IV infusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental work or oral surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery other than oral surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebotomy or finger stick blood draw in home or clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonics or other alternative healthcare procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body piercing Where was piercing performed <input type="checkbox"/> Commercial parlor <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tattoo Where was tattoo received <input type="checkbox"/> Commercial parlor <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used non-injected street drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or more male sex partners How many? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or more female sex partners How many? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment for a sexually-transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever donated blood (or was denied due to hepatitis infection) Year of last blood donation _____ Location of last donation _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**RISK FACTOR DETAILS:**

<b>COMPLETED BY</b>	<b>LHD</b>	<b>PHONE</b> ( )	<b>DATE COMPLETED</b> / /	<b>REPORT TO CDPH</b> / /
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