



# ACUTE HEPATITIS B OR C CASE REPORT

Mail to: California Department 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

PATIENT'S NAME Last First Middle initial

DOB (month/day/year) / / AGE (enter age and check one)  Days  Weeks  Months  Years DATE OF REPORT / /

ADDRESS NUMBER & STREET CITY/TOWN STATE ZIP CODE

COUNTY COUNTRY OF BIRTH  USA  OTHER: HOME PHONE ( ) OTHER PHONE (specify) ( )

GENDER  F  M  FTM  MTF  Other  Unknown PATIENT'S OCCUPATION  Hospital/Medical/Dental  Long-term care facility  Other:  Pregnant?  Yes  No  Unknown  Public safety (e.g. law enforcement)  Correctional facility  Unknown

ETHNICITY (check one)  Hispanic/Latino  Non-Hispanic/Non-Latino  Unknown RACE (check all that apply)  Black/African-American  Native American/Alaskan Native  White  Unknown  Other: Asian: Please specify:  Asian Indian  Hmong  Thai  Cambodian  Japanese  Vietnamese  Chinese  Korean  Other Asian:  Filipino  Laotian Pacific Islander: Please specify:  Native Hawaiian  Guamanian  Samoan  Other Pacific Islander:

REASONS FOR TESTING (check all that apply)  Symptoms of acute hepatitis  Evaluation of liver enzymes  Exposure to case  Prenatal screening  Unknown  Other: PHYSICIAN NAME (name, facility) CMR ID PHYSICIAN PHONE ( ) CDPH ID

## CLINICAL AND DIAGNOSTIC DATA

SYMPTOMATIC?  Yes  No  Unknown If asymptomatic, report as probable chronic hepatitis SYMPTOMS (check all)  Jaundice  Anorexia  Clay stools  Dark urine  Abdominal pain  Fatigue  Diarrhea  Other: DIED OF HEPATITIS?  Yes  No  Unknown IF YES, DATE OF DEATH / / ONSET OF SYMPTOMS / / DIAGNOSIS DATE (test date) / /

HOSPITALIZED?  Yes  No  Unknown HOSPITAL NAME ADMIT DATE / / DISCHARGE DATE / /

HEPATITIS B VACCINE HISTORY Date unknown Vaccine Type  Dose #1 Date / /   Dose #2 Date / /   Dose #3 Date / /   None  Unknown If <18 years, why not vaccinated? Tested for anti-HBs within 1-2 months after the last dose?  Yes  No If yes, was serum anti-HBs ≥ 10mIU/ml?  Yes  No

HEPATITIS A VACCINE HISTORY Date Unknown Vaccine Type  Dose #1 Date / /   Dose #2 Date / /   None  Unknown

LIVER ENZYME LEVELS AT DIAGNOSIS ALT [SGPT] Result / / AST [SGOT] Result / / Bilirubin Result / /

VIRAL HEPATITIS DIAGNOSTIC TESTS				
	Positive	Negative	Unknown	Month/Day/Year
Anti-HCV* Signal to cut-off ratio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /
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"/>	/ /

## DIAGNOSIS

CONFIRMED ACUTE HEPATITIS 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

CONFIRMED ACUTE HEPATITIS C: 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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