



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

HEPATITIS A CASE REPORT

CASE IDENTIFICATION AND DEMOGRAPHICS

PATIENT'S NAME—Last		First		Middle initial	PHONE ()	
STREET ADDRESS		CITY	STATE	ZIP	COUNTY	
DOB (month/day/year) / /	AGE (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years		SEX <input type="checkbox"/> M <input type="checkbox"/> F	COUNTRY OF BIRTH <input type="checkbox"/> USA <input type="checkbox"/> OTHER: _____	DATE OF REPORT / /	
ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		RACE (check all that apply) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____			<input type="checkbox"/> Asian: Please specify: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian: <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian	<input type="checkbox"/> Pacific Islander: Please specify: <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____
PATIENT'S OCCUPATION/SETTING (check all that apply and specify) <input type="checkbox"/> Food service <input type="checkbox"/> Day care/preschool <input type="checkbox"/> School <input type="checkbox"/> Health care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other			REASONS FOR TESTING (check all that apply) <input type="checkbox"/> Symptoms of acute hepatitis <input type="checkbox"/> Exposure to case <input type="checkbox"/> Evaluation of liver enzymes <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____			
SPECIFY OCCUPATION: _____			PHYSICIAN NAME (name, facility)		PHYSICIAN PHONE ()	
					CDPH ID	

CLINICAL AND DIAGNOSTIC DATA

SYMPTOMATIC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	SYMPTOMS (check all that apply) <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: _____	SYMPTOM ONSET DATE / /	DIED OF HEPATITIS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
		DIAGNOSIS DATE (test date) / /	if yes, date of death / /
HOSPITALIZED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	HOSPITAL NAME	ADMIT DATE / /	DISCHARGE DATE / /

HEPATITIS A DIAGNOSTIC TESTS (required)	OPTIONAL RISK FACTOR INFORMATION																																																																			
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DIAGNOSIS	During the infectious period
<p>An acute illness with discrete onset of symptoms AND(1) jaundice or (2) elevated serum aminotransferase levels</p> <p><input type="checkbox"/>Confirmed hepatitis A case: anti-HAV IgM positive or epidemiologically linked with a laboratory-confirmed case</p>	Was the case employed as a food handler
	Did the case prepare food at any public or private gatherings
	Was the case employed as a health care worker with direct patient contact
	Was the case an attendee or employee of a child care center, nursery or preschool
	If "Yes", provide job description, dates worked during communicable period, supervisor's name and phone number, etc. in Comments box on the next page.

*See hepatitis A quicksheet for additional information

INFECTION TIMELINE

Incubation period: 15-50 days

Infectious period: Transmission most likely to occur 1-2 weeks before onset of illness until seven days after jaundice onset

Post-exposure prophylaxis: Single-antigen HAV vaccine for healthy persons aged 12 months-40 years (consider vaccine in persons aged 41-59*) or immune globulin, 0.02 cc/kg, IM as soon as possible and within two weeks of exposure.

Enter date of onset* in onset box.

Count backward and forward to determine probable exposure and communicable periods.

	EXPOSURE PERIOD	ONSET*	COMMUNICABLE PERIOD
Days from onset:	-50 days	-14 days	+7 days
Calendar dates:	<div style="border: 1px solid black; padding: 5px; width: 100%;"> / / (month/day/year) </div>	<div style="border: 1px solid black; padding: 5px; width: 100%;"> / / (month/day/year) </div>	<div style="border: 1px solid black; padding: 5px; width: 100%;"> / / (month/day/year) </div>

*onset of jaundice or onset of symptoms if not jaundiced

SUSCEPTIBLE CONTACT* MANAGEMENT/FOLLOW-UP

HOUSEHOLD/DAYCARE ROSTER AND OTHER KNOWN OR PRESUMED CONTACT

Name	age	dates of exposure	last useful PEP date†	type of contact (household, sexual)	prophylaxis			vaccinated >1mo. before exposure	Reason PEP not given	Phone #
					IG	Vax	None			
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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*See hepatitis A quicksheet for definition of susceptible contact †2 weeks after last exposure date

COMMENTS

COMPLETED BY	LHD	DATE COMPLETED	PHONE	REPORT TO CDPH
		/ /	()	/ /