



ACUTE HEPATITIS B OR C CASE REPORT

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

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 Other Asian: Chinese Korean 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 PHYSICIAN PHONE () CMR ID CDPH ID

CLINICAL AND DIAGNOSTIC DATA

SYMPTOMATIC? Yes No Unknown If asymptomatic, report as probable chronic hepatitis SYMPTOMS (check all that apply) Jaundice Dark urine Diarrhea Anorexia Abdominal pain Other Clay stools Fatigue 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*	<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"/>	/ /

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:

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