HEPATITIS E CASE INVESTIGATION - Page 1 of 3

Indiana State Department of Health
State Form 49691 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✗
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of: ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Diarrhea
- ○ Nausea/Vomiting
- ○ Abdominal Pain
- ○ Pale Stool
- ○ Dark Urine
- ○ Fatigue
- ○ Loss of Appetite
- ○ Jaundice
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

SGOT (AST)

SGPT (ALT)

Bilirubin

Hepatitis A IgM Antibody Result:
○ Positive ○ Negative ○ Unknown/Not Tested

Hepatitis B Surface Antigen Result:
○ Positive ○ Negative ○ Unknown/Not Tested

Hepatitis B Core IgM Antibody Result:
○ Positive ○ Negative ○ Unknown/Not Tested

Hepatitis C Antibody Result:
○ Positive ○ Negative ○ Unknown/Not Tested

Hepatitis E IgM Antibody Result:
○ Positive ○ Negative ○ Unknown/Not Tested

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code**

Physician/Hospital Phone

If female, was the patient pregnant?

○ Yes ○ No ○ Unknown **If Yes, due date:** / /

Was the patient hospitalized?

○ Yes ○ No **If Yes, admission date:** / /

Discharge date: / /

Hospital:

Did patient die?

○ Yes ○ No

Section 3. Risk Factors

During the 9 weeks prior to illness onset:

Was the patient a contact of a confirmed or suspected hepatitis E case?

○ Yes ○ No ○ Unknown **If Yes, name:**

Phone number: - -

If Yes, specify type of contact:

○ Sexual ○ Household ○ Other, specify:

Did the patient travel outside the United States?

○ Yes ○ No ○ Unknown

If Yes, where

Date of departure / / **Date of return** / /

Did the patient eat any raw shellfish?

○ Yes ○ No ○ Unknown

If Yes, which shellfish

Where

Date / /

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Section 3. Risk Factors (continued)

Did the patient have contact with untreated water? ○ Yes ○ No ○ Unknown

If Yes, where

Date

Did the patient have any contact with pigs? ○ Yes ○ No ○ Unknown

If Yes, where

Date

Was the patient suspected as being part of a common-source foodborne or waterborne outbreak?

○ Yes ○ No ○ Unknown

If Yes, describe

Does the patient know anyone else who has recently had an illness characterized by diarrhea, nausea/vomiting, or jaundice?

○ Yes ○ No ○ Unknown

If Yes, name:

Phone number: - -

Onset date: / /

Relationship:

Was this person exposed to any of the same risk factors as the patient?

○ Yes ○ No ○ Unknown

If Yes, describe

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number - -

Date / /