Maryland Department of Health and Mental Hygiene
Acute Viral Hepatitis Case Report

Acute Viral Hepatitis is a reportable disease in Maryland. The health department investigates cases of acute hepatitis in order to assess disease incidence in Maryland. We have received laboratory results for your patient indicating that they may have acute hepatitis. Please help with our public health surveillance efforts by promptly providing the information requested on this form.

PATIENT NAME: _____ **DATE OF BIRTH:** _____ / _____ / _____

DHMH #

SOURCE OF REPORT: ☐ Lab ☐ ICP ☐ Physician ☐ Other: _____ **DATE OF REPORT:** _____ / _____ / _____

NAME OF SOURCE: _____ **PHONE:** ( ) _____ - _____

PRIMARY PHYSICIAN: _____ **PHONE:** ( ) _____ - _____

CLINICAL DATA

REPORTING PHYSICIAN'S DIAGNOSIS OF HEPATITIS: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ Other

PLEASE DO NOT REPORT CASES OF CHRONIC HEPATITIS OR CHRONIC CARRIERS!!

REASON FOR TESTING: (Check all that apply)

☐ Symptoms of acute hepatitis
☐ Screening of asymptomatic patient with reported risk factors
☐ Screening of asymptomatic patient with no known risk factors
☐ Prenatal screening
☐ Evaluation of elevated liver enzymes
☐ Blood or organ donor screening
☐ Follow-up testing for previous marker of viral hepatitis
☐ Corrections Immunity Study
☐ Other: (specify) _____
☐ Unknown

SIGNS/SYMPTOMS OF HEPATITIS (this episode)

Check all that apply:

☐ None ☐ Fatigue ☐ Dark urine ☐ Pale stools ☐ Fever ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Anorexia (loss of appetite)

DATE OF FIRST SYMPTOM (ONSET) …… ____ / ____ / _____
DATE OF DIAGNOSIS …… ____ / ____ / _____
WAS THE PATIENT JAUNDICED? …… ☐ Yes ☐ No
WAS THE PATIENT HOSPITALIZED FOR HEPATITIS? …… ☐ Yes ☐ No
DID THE PATIENT DIE FROM HEPATITIS? …… ☐ Yes ☐ No

TYPE OF HBV/HCV INFECTION: (Based on your evaluation of this patient, what type of infection does this patient have?)

Hepatitis B
☐ Newly Acquired (probably infected within the last six months)
☐ Chronic Infection (probably infected more than 6 months ago, even if first recognized now)
☐ Carrier
☐ Resolved
☐ Perinatal
☐ Unsure

Hepatitis C
☐ Newly Acquired (probably infected within the last six months)
☐ Chronic Infection (probably infected more than 6 months ago, even if first recognized now)
☐ Resolved
☐ Unsure

DHMH #

LABORATORY RESULTS

Laboratory Information is *essential* in characterizing this patient's infection. Please report all of the following test results, or, **preferably, include a copy of the patient's laboratory report(s).** **(☐ Lab reports attached)**

LIVER ENZYME LEVELS AROUND TIME OF DIAGNOSIS	RESULT	REFERENCE RANGE	DATE
ALT [SGPT]			
AST [SGOT]			

SEROLOGIC/DIAGNOSTIC TESTS: (check all that apply)	POS	NEG	UNK	DATE
Hepatitis A				
Total antibody to hepatitis A virus [Total anti-HAV] ……..	☐	☐	☐	_____
IgM antibody to hepatitis A virus [IgM anti-HAV] ……...	☐	☐	☐	_____
Hepatitis B				
Total antibody to hepatitis B core antigen [Total anti-HBc] ……	☐	☐	☐	_____
IgM antibody to hepatitis B core antigen [IgM anti-HBc] ……..	☐	☐	☐	_____
Hepatitis B surface antibody [HBsAb] ……	☐	☐	☐	_____
Hepatitis B surface antigen [HBsAg] ……...	☐	☐	☐	_____
Hepatitis B e antibody [HBeAb] ……...	☐	☐	☐	_____
Hepatitis B e antigen [HbeAg] ……..	☐	☐	☐	_____
Hepatitis B DNA: _____				_____
Hepatitis C				
Antibody to hepatitis C virus [anti-HCV] ……	☐	☐	☐	_____
- anti-HCV signal to cut-off ratio: _____				
Supplemental anti-HCV assay [e.g., RIBA] ……	☐	☐	☐	_____
HCV RNA [e.g., PCR] ……	☐	☐	☐	_____
Hepatitis C Genotype: ☐ 1a ☐ 1b ☐ Other: ____				_____
Hepatitis D				
Antibody to hepatitis D virus [anti-HDV] ……	☐	☐	☐	_____
Hepatitis E				
Antibody to hepatitis E virus [anti-HEV] ……..	☐	☐	☐	_____

IMMUNIZATION HISTORY

HEPATITIS A	**YES**	**NO**	**UNK**
Has the patient ever received the hepatitis A vaccine? ……	☐	☐	☐
If yes, how many doses? ☐ 1 ☐ 2 or more			
In what year was the last dose received? _____			
Has the patient ever received immune globulin (IG)? ……..……	☐	☐	☐
If yes, when was the last IG dose received? ____(mo) / _____(yr)			

HEPATITIS B	**YES**	**NO**	**UNK**
Has the patient ever received the three dose series of hepatitis B vaccine? ……...	☐	☐	☐
If yes, what year? _____			
AND was the patient tested for antibody within 1-6 months after the last dose? .. ……..	☐	☐	☐
If yes, was the antibody test ☐ Pos ☐ Neg ☐ Unknown			

DHMH #

RISK ASSESSMENT

HEPATITIS A: DURING THE 2 - 6 WEEKS PRIOR TO ONSET OF SYMPTOMS:	YES	NO	UNK
1. was the patient a child or employee in a nursery, day care center, or preschool? ……	☐	☐	☐
2. was the patient a household contact of a child or employee in a nursery, day care center, or preschool?	☐	☐	☐
3. was the patient a contact of a confirmed or suspected hepatitis A case? ……..	☐	☐	☐
If yes, type of contact: ☐ Sexual ☐ Household (non-sexual) ☐ Other			
4. was the patient employed as a food handler? ……..	☐	☐	☐
5. did the patient eat raw shellfish? ……	☐	☐	☐
6. was the patient suspected as being part of a common-source foodborne or waterborne outbreak? …….	☐	☐	☐
7. did the patient travel outside of the U.S. or Canada? ……..	☐	☐	☐
If yes, where: ☐ So/Central America (including Mexico) ☐ Africa ☐ Caribbean ☐ Middle East ☐ Asia/So.Pacific ☐ Australia/New Zealand ☐ Other _____			
Duration of stay: ☐ 1-3 Days ☐ 4-7 Days ☐ More than 7 Days			
8. did the patient inject street drugs? ……	☐	☐	☐
9. did the patient use street drugs but not inject? ……	☐	☐	☐
10. how many male sex partners did the patient have? ☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown			
11. how many female sex partners did the patient have? ☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown			

HEPATITIS B: DURING THE 6 WEEKS TO 6 MONTHS PRIOR TO ONSET OF SYMPTOMS OR HEPATITIS C: DURING THE 2 WEEKS TO 6 MONTHS PRIOR TO ONSET OF SYMPTOMS:	YES	NO	UNK
1. was the patient a contact of a confirmed or suspected acute or chronic hepatitis B or C case? ……	☐	☐	☐
If yes, type of contact: ☐ Sexual ☐ Household (non-sexual) ☐ Other			
2. was the patient employed in a medical, dental or other field involving contact with human blood? …….....	☐	☐	☐
If yes, degree of blood contact: ☐ Frequent (several times weekly) ☐ Infrequent			
3. did the patient receive blood or blood products (transfusion)? ……..	☐	☐	☐
If yes, specify date(s) received: From ____ / ____ / _____ to ____ / ____ / _____			
4. was the patient associated with a dialysis or kidney transplant unit? ……	☐	☐	☐
If yes, type of association: ☐ Patient ☐ Employee ☐ Contact of patient or employee			
5. did the patient use needles for injection of street drugs? ……...	☐	☐	☐
6. did the patient use street drugs but not inject? ……	☐	☐	☐
7. how many male sex partners did the patient have? ☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown			
8. how many female sex partners did the patient have? ☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown			
9. did the patient have			
dental work or oral surgery? ……	☐	☐	☐
other surgery? ……	☐	☐	☐
acupuncture? ……..	☐	☐	☐
tattooing? ……	☐	☐	☐
an accidental stick or puncture with a needle or other object contaminated with blood? … .	☐	☐	☐

ADDITIONAL NOTES

PERSON COMPLETING FORM: _____ **DATE:** ____ / ____ / _____

DHMH #

WORK SHEET

FOR USE BY LOCAL HEALTH DEPARTMENTS TO DETERMINE THE PATIENT'S MOST PROBABLE SOURCE OF INFECTION

CASE DEFINITION FOR REPORTING OF ACUTE VIRAL HEPATITIS

Newly acquired illness with: 1) discrete onset of symptoms consistent with acute viral hepatitis, and
2) jaundice or elevated serum aminotransferase levels

Hepatitis A: 1) IgM anti-HAV positive.

Hepatitis B: 1) IgM anti-HBc positive (if done) or HBsAg positive, and
2) IgM anti-HAV negative (if done).

Hepatitis C: 1) Serum alanine aminotransferase levels greater than 7 times the upper limit of normal, and
2) IgM anti-HAV negative, and
3) IgM anti-HBc negative (if done) or HBsAg negative, and
4) Anti-HCV positive (repeat reactive) by EIA, verified by an additional more specific assay
(e.g. RIBA for anti-HCV or RT-PCR for HCV RNA) or by an average EIA signal to cutoff ratio of >=3.8,
OR
Anti-HCV positive by RIBA alone
OR
HCV RNA positive

Hepatitis D: 1) HBsAg or IgM anti-HBc positive, and
2) Anti-HDV positive

Hepatitis E: 1) Anti-HEV positive

Reporting Center/Physician Address and Phone # _____
If patient was hospitalized for hepatitis, give name of hospital _____
Lab results of other liver function tests: Bilirubin _____ Alk Phos _____ GGT _____

FURTHER INFORMATION FOR ADMITTED RISK FACTORS AND SOURCES LISTED ON PREVIOUS PAGE

IF APPLICABLE:

1. Name, address, and phone # of child care center _____
2. Name and address of school, grade, classroom attended _____
3. Name, address, and phone # of restaurant where food handler worked (Hep A only) _____
4. Food history of patient for the 2-6 wks prior to onset: (Hep A only)
   a. Name and location of restaurants _____
   b. Name and location of food stores _____
   c. Name and location of bakery _____
   d. Group meals attended (e.g. reception, church, meeting, etc.) _____
   e. Location raw shellfish purchased _____
5. Name, address, and phone # of known hepatitis A or hepatitis B contact _____
6. Contacts requiring prophylaxis for Hep A or Hep B – list name, age, relationship to case, information about IG, HBIG and Vaccine on separate page
7. If transfused, NOTIFY BLOOD CENTER! Name of blood center _____
   a. Number of units of whole blood, packed RBC or frozen RBC received _____
   b. Specify type of blood product (e.g. albumin, fibrinogen, factor VIII, etc.) _____
8. IF DONOR, name, address, and phone # of donor or plasmapheresis center _____
9. Name, address, and phone # of dialysis center _____
10. Name, address, and phone # of dentist or oral surgeon _____
11. If other surgery performed, name, address, and phone # of location _____
12. Name, address, and phone # of acupuncturist or tattoo parlor _____
13. If patient is currently pregnant, give obstetrician's name, address, and phone # and estimated location of delivery _____

Comments: _____
_____
_____
_____
_____
_____

Investigator: _____ Date of interview: _____