SUSPECTED ACUTE HEPATITIS A DATA COLLECTION TOOL for CLINICIANS

TN Department of Health

This tool and associated documentation may be faxed directly to the local or regional health office (https://www.tn.gov/health/health-program-areas/localdepartments.html)
OR the Tennessee Department of Health at FAX (615) 741-3857

PROVIDER INFORMATION

Provider Name (name, facility): _____ Provider Phone: _____
Patient Interviewed? ☐ Yes ☐ No Date of Interview: _____/_____/_____

PATIENT INFORMATION

Patient Name (Last, First): _____ Phone: _____ Age:_____
Address: _____ Gender:_____
City/State: _____ Zip:_____

CLINICAL INFORMATION

Symptoms? *(check all that apply)*

☐ None ☐ Clay stools ☐ Anorexia ☐ Fatigue
☐ Jaundice ☐ Dark urine ☐ Abdominal pain ☐ Headache
☐ Diarrhea ☐ Other:_____

Illness Onset Date: _____/_____/_____

What is Hepatitis A?
An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., jaundice, fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain).

RISK FACTOR INFORMATION

In the 7 weeks before onset of illness:

Yes	No	Unk	
☐	☐	☐	Homeless
☐	☐	☐	One or more male sex partners
☐	☐	☐	One or more female sex partners
☐	☐	☐	Recreational drug use?

Method of drug use: ☐ Injected ☐ Smoked ☐ Snorted ☐ Ingested
Type of drug(s):_____

Yes	No	Unk	
☐	☐	☐	Patient traveled

Travel Type: Domestic International
Location _____
Travel dates:_____

Yes	No	Unk	
☐	☐	☐	Contact with foreign traveler
☐	☐	☐	Contact to a confirmed or suspected case of hepatitis A

Type of contact: ☐ Household ☐ Sexual ☐ Child care ☐ Other:_____

Yes	No	Unk	
☐	☐	☐	Worked or volunteered with homeless
☐	☐	☐	Food service worker

Location_____
Dates worked there_____

HOUSING (IF HOMELESS)

Did patient spend the night in any of the following places? ***(Check all that apply)***

Yes	No	Unk	
☐	☐	☐	Friend or family member home

If YES, provide any contacts in Contacts box below
Date of last stay: _____/_____/_____

Yes	No	Unk	
☐	☐	☐	Shelter

If YES, shelter name_____
Location_____
Date of last stay: _____/_____/_____

Yes	No	Unk	
☐	☐	☐	Street

If YES, provide cross-streets and detailed location
_____

Yes	No	Unk	
☐	☐	☐	Jail/prison

Location_____
Date of release: _____/_____/_____

Yes	No	Unk	
☐	☐	☐	Other:_____

Dates of stay:_____

CONTACTS (*Name, phone, relationship*)

COMMENTS (*Include alternative means of contact for patient follow-up, if applicable*)