

Hepatitis A Case Report Form

Hepatitis A Fast Facts

Agent: Hepatitis A virus (HAV)

Incubation: 15-50 days (average 28 days)

Mode of Transmission: Person-to-person through the fecal-oral route; ingestion of contaminated food or water

Avg Length of Illness: 1-2 weeks

Prevention- within 2 weeks of last known exposure: vaccine (most persons) and (for certain persons) immune globuline (gammaSTAN)

Patient Demographics

Date of Interview ____/____/____

Last Name _____ First Name _____

Middle Name _____ Suffix _____

DOB (MM/DD/YYYY) ____/____/____ Age ____ Years/Months/Days (circle one)

Patient's Parent/Guardian Name (if applicable) _____

Gender ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male
☐ Refused to Answer ☐ Additional Gender Identity (please specify) _____

Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Refused to Answer

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Multiple Races ☐ Unknown
if other, please specify _____

Public Health Region _____

Is patient experiencing homelessness? : ☐ Yes ☐ No ☐ Unknown

Residential Address Number & Street Apartment/Unit Number

City _____ County _____ Zip _____

Phone (____) _____ Alternate Phone(s) (____) _____

E-mail Address _____

Other Electronic Contact Information (e.g., Grindr, Instagram, etc.)

Primary Language: ☐ English ☐ Spanish ☐ Other: please specify _____

Pregnant: ☐ Yes ☐ No ☐ Unknown **Estimated Delivery Date** ____/____/____

Occupation/ School _____ **Occupation/School setting** _____

Physician name and facility _____

Physician phone (____) _____

Reason for testing

- ☐ Routine physical ☐ Symptoms of acute hepatitis ☐ Evaluation of liver enzymes
☐ Exposure to case ☐ Possible cholestatic hepatitis
☐ Unknown ☐ Other _____

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown

Onset date ____/____/____

Jaundice ☐ Yes ☐ No ☐ Unknown

Jaundice onset date ____/____/____

Diarrhea ☐ Yes ☐ No ☐ Unknown

Diarrhea onset date ____/____/____

Vomiting ☐ Yes ☐ No ☐ UnknownAbdominal discomfort ☐ Yes ☐ No ☐ UnknownLoss of appetite ☐ Yes ☐ No ☐ UnknownFever ☐ Yes ☐ No ☐ UnknownLight, clay-colored stool ☐ Yes ☐ No ☐ UnknownDark urine ☐ Yes ☐ No ☐ UnknownItching ☐ Yes ☐ No ☐ UnknownHeadaches ☐ Yes ☐ No ☐ UnknownFatigue ☐ Yes ☐ No ☐ Unknown

Other symptoms (specify) _____

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

ALT [SGPT] result _____ Upper limit normal (ALT) _____ ALT draw date ____/____/____

AST [SGOT] result _____ Upper limit normal (AST) _____ AST draw date ____/____/____

Bilirubin (total) _____ Bilirubin draw date ____/____/____

HEPATITIS A IMMUNIZATION HISTORY – Indicate Twinrix, monovalent or unknown

Dose Number	1	2	3	4
Type	<input type="checkbox"/> Twinrix (Hep A/B) <input type="checkbox"/> Monovalent Hep A <input type="checkbox"/> Unknown	<input type="checkbox"/> Twinrix (Hep A/B) <input type="checkbox"/> Monovalent Hep A <input type="checkbox"/> Unknown	<input type="checkbox"/> Twinrix (Hep A/B) <input type="checkbox"/> Monovalent Hep A <input type="checkbox"/> Unknown	<input type="checkbox"/> Twinrix (Hep A/B) <input type="checkbox"/> Monovalent Hep A <input type="checkbox"/> Unknown
Date of dose				
Unknown date?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION

Hospitalized for hepatitis? ☐ Yes ☐ No ☐ Unknown

If yes, provide details below.

Hospital Name _____

Street address _____

City _____ State _____ Zip _____

Phone (____) _____

Admit date (mm/dd/yyyy) ____/____/____ Discharge/transfer date (mm/dd/yyyy) ____/____/____

Medical record number _____

Discharge diagnosis _____

Did the patient die from Hepatitis A? ☐ Yes ☐ No ☐ Unknown If yes, date of death (mm/dd/yyyy) ____/____/____

Diagnostic tests

IgM antibody to Hepatitis A virus (IgM anti-HAV)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
Total antibody to Hepatitis A virus (total anti-HAV)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
Hepatitis A Nucleic Acid Test (NAT)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
Hepatitis B surface antigen (HBsAg)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
IgM antibody to Hepatitis B core antigen (IgM anti-HBc)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
Total antibody to Hepatitis B core antigen (total anti-HBc)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
Antibody to Hepatitis C virus (anti-HCV)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
Supplemental anti-HCV assay (e.g., RIBA)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done
HCV RNA (e.g., PCR)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg/Inconclusive	<input type="checkbox"/> Unk/Not done

PCR AND GENOTYPING RESULTS

Was specimen sent to CDC for genotyping? ☐ Yes ☐ No ☐ Unknown

CDC genotype results _____ CDC genotype result date ____/____/____

CDC genotype sub-cluster _____

CALCULATE EXPOSURE PERIOD

Incubation Period is 15-50 days (mean of 28 days) prior to onset of acute illness

Onset date (onset of acute symptoms) ____/____/____

Beginning of exposure period (onset minus 50 days) ____/____/____

End of exposure period (onset minus 14 days) ____/____/____

Exposure period Begin ____/____/____ End ____/____/____

- What do you think caused to you to become ill? _____

During the 15-50 day period before illness onset (dates above), did the patient have any of the following exposures?

- Contact with someone with confirmed or suspected Hepatitis A virus infection? ☐ Yes ☐ No ☐ Unknown
- If yes, what was the relationship? ☐ Parent or Guardian ☐ Spouse or significant other
- ☐ Sexual ☐ Friend ☐ Child ☐ Other (please specify) _____

INTERNATIONAL TRAVEL

- Did the patient travel outside the U.S. ☐ Yes ☐ No ☐ Unknown
- If any travel, where? (city, country)
- Location: _____
Dates of travel ____/____/____ to ____/____/____
 - Location: _____
Dates of travel ____/____/____ to ____/____/____

DOMESTIC TRAVEL

- Did the patient travel outside their county of residence? ☐ Yes ☐ No ☐ Unknown
- If any travel, where? (city, country)
- Location: _____
Dates of travel ____/____/____ to ____/____/____
 - Location: _____
Dates of travel ____/____/____ to ____/____/____

SEX AND DRUG INFORMATION

Please ask the following questions about the exposure time period listed above:

- Did the patient have sexual (vaginal, anal, oral) contact with (mark all that apply)?
- ☐ Male ☐ Female ☐ Transgender ☐ Refused ☐ Don't know/unknown ☐ None
- How many sexual partners has the person had? ____
- Had a sexual partner that used/s recreational drugs? ☐ Yes ☐ No ☐ Unknown
- Had a male sex partner who has had sex with men? ☐ Yes ☐ No ☐ Unknown
- Sex with someone the patient didn't know (anonymous sex)? ☐ Yes ☐ No ☐ Unknown
- Did the patient use recreational drugs? ☐ Yes ☐ No ☐ Unknown
- Shared drug equipment (even once)? ☐ Yes ☐ No ☐ Unknown

If yes, please complete table below.

	Opioids	Heroin	Meth	Cocaine	Other (specify)
Smoke					
Snort					
Inject					
By mouth					

Exposure period Begin ____/____/____ End ____/____/____

Where the patient spends the night**During the exposure period (dates above), did the patient spend the night at any of the following places? Only include locations differing from the home address reported by the patient.**

	Y/N/U	Name	Address/Phone	Start date	End date
Friend or family member home (1)			(____) _____		
Friend or family member home (2)			(____) _____		
Shelter (1)			(____) _____		
Shelter (2)			(____) _____		
On the street (1)			(____) _____		
On the street (2)			(____) _____		
Jail, prison, or detention center (1)			(____) _____		
Jail, prison, or detention center (2)			(____) _____		
Rehab, detox, or congregate living facility (1)			(____) _____		
Rehab, detox, or congregate living facility (2)			(____) _____		
Other type of location (1), specify _____ _____			(____) _____		
Other type of location (2), specify _____ _____			(____) _____		

o In the settings listed above, was the patient around anyone ill with symptoms of hepatitis A?

☐ Yes ☐ No ☐ Unknown

Calculate **INFECTIOUS** Period:

Infectious Period is 14 days prior to onset of symptoms through one week following onset of symptoms.

Date of symptom onset: ____/____/____

Beginning of infectious period (onset date minus 14 days) : ____/____/____

End of infectious period (onset date plus 7 days) : ____/____/____

SUSCEPTIBLE CONTACTS

Ask all of the following questions for the infectious period listed above:

- Did the case patient share the same household with others? ☐ Yes ☐ No ☐ Unknown
 - How many people were in the household? _____
- Did the case patient handle or prepare food for others (non-work related)? ☐ Yes ☐ No ☐ Unknown
 - How many people did the case patient prepare food for? _____
 - Describe food preparation: _____

- Was the case patient employed as a food handler? ☐ Yes ☐ No ☐ Unknown
 - If yes, provide name, location and dates of work: _____

 - Did patient work while experiencing diarrhea? ☐ Yes ☐ No ☐ Unknown
 - Did the patient wear gloves? ☐ Yes ☐ No ☐ Unknown
 - Rate hand hygiene practices while working: ☐ Good ☐ Poor ☐ Unknown ☐ Other _____
 - Describe patient's role at work while infectious: _____

- Was the case patient a health care worker? ☐ Yes ☐ No ☐ Unknown
 - If yes, provide name, location and dates of work: _____

- Did the case have sexual contacts? ☐ Yes ☐ No ☐ Unknown
 - How many are named _____
 - How many are known but not disclosed _____
 - How many are anonymous _____
- Did the case patient use any recreational drugs? ☐ Yes ☐ No ☐ Unknown
 - If yes, Did the case patient **inject** any recreational drugs ☐ Yes ☐ No ☐ Unknown
- Did the case patient use any recreational drugs **with other people**? ☐ Yes ☐ No ☐ Unknown
 - If yes, did they share injection equipment (needles, syringes, cookers, cottons)? ☐ Yes ☐ No ☐ Unknown
 - If yes, how many people did they share equipment with? _____

Infectious Period Begin ____/____/____ End ____/____/____

WHERE THE PATIENT SPENDS THE NIGHT

☐ Was the case patient experiencing homelessness during the infectious period? ☐ Yes ☐ No ☐ Unknown

During the infectious period (dates above), did the patient spend the night at any of the following places? Only include locations differing from the home address reported by the patient.

	Y/N/U	Name	Address/Phone	Start date	End date
Friend or family member home (1)			(____) _____		
Friend or family member home (2)			(____) _____		
Shelter (1)			(____) _____		
Shelter (2)			(____) _____		
On the street (1)			(____) _____		
On the street (2)			(____) _____		
Jail, prison, or detention center (1)			(____) _____		
Jail, prison, or detention center (2)			(____) _____		
Rehab, detox, or congregate living facility (1)			(____) _____		
Rehab, detox, or congregate living facility (2)			(____) _____		
Other type of location (1), specify _____			(____) _____		
Other type of location (2), specify _____					

Risk History (continued)

Infectious Period Begin ____/____/____ End ____/____/____

List all contacts, during the **infectious period**, below

(ENTER THESE CONTACTS INTO REDCap CONTACT FORM, and LINK TO CASE)

Name/ Age	Address	Phone	Dates of contact	Type of contact	Immune? <i>include vaccine type (monovalent or Hep A/B) and dates of vaccination, if known</i>	PEP* offered and date received	
						Offered Y/N	Date rec'd

* Follow guidance for PEP if contact is identified within 2 weeks of the most recent exposure.

Case Classification

☐ Confirmed ☐ Not a case

CSTE Case Definition (2012)**Clinical Description**

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and either a) jaundice, or b) elevated serum alanine aminotransferase (ALT) or aspartate aminotransferase (AST) levels.

Laboratory Criteria for Diagnosis

Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive

Case Classification– Confirmed

A case that meets the clinical case definition and is laboratory confirmed, OR

A case that meets the clinical case definition and occurs in a person who has an epidemiologic link with a person who has laboratory-confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15-50 days before the onset of symptoms).

<i>Exposure period</i>	Begin	/	/	End	/	/
------------------------	-------	---	---	-----	---	---

During the 15-50 day period before illness onset (dates above), did the patient have any of the following food exposures?

	Y/N/U	What kind?	Where purchased/eaten	Date eaten
Raw or undercooked shellfish (1)				
Raw or undercooked shellfish (2)				

- Please list all restaurants, cafeterias, group gatherings (e.g. party, potluck) or community events (e.g. fairs, picnics), including ready-to-eat foods from delis, supermarkets and street vendors, and any fresh fruit and vegetables.

[illegible]

Food and water exposure history (continued)

- Participate in aquatic activities (surfing or swimming in ocean, water parks, streams, etc.)?

☐ Yes ☐ No ☐ Unknown

Specify aquatic activities and locations _____

Water sources (including drinking water and residential water source)

☐ Municipal tap ☐ Filtered tap ☐ Private well ☐ Untreated surface

☐ Bottled, specify: _____

Household and daycare exposure history

During the 15-50 day period before illness onset (dates above), did the patient have any of the following exposures?

- Household contact of a child in diapers? ☐ Yes ☐ No ☐ Unknown

- If yes, was the child internationally adopted? ☐ Yes ☐ No ☐ Unknown

- If yes, from where? _____

- Household contact of a child or employee in a child care center, nursery, or preschool?

☐ Yes ☐ No ☐ Unknown

- If yes, was there an identified Hepatitis A case in the child care facility? ☐ Yes ☐ No ☐ Unknown

- If yes, when? ____/____/____

Household travel

- Did anyone else in the **household** travel outside the U.S.? ☐ Yes ☐ No ☐ Unknown

- If travel among household, where? (city, country)

- Location: _____

Dates of travel ____/____/____ to ____/____/____

- Did someone from **outside the U.S. visit**? ☐ Yes ☐ No ☐ Unknown

- If visitor, from where? (city, country)

- Origin of visitor: _____

- Name(s) of visitors and relationship _____

Dates of visit ____/____/____ to ____/____/____

- Did anyone else in the household travel **outside their county of residence**? ☐ Yes ☐ No ☐ Unknown

- If travel among household, where? (city, country)

- Location: _____

Dates of travel ____/____/____ to ____/____/____

- Did someone from **outside their county of residence visit**? ☐ Yes ☐ No ☐ Unknown

- If visitor, from where? (city, country)

- Origin of visitor: _____

- Name(s) of visitors and relationship _____

Dates of visit ____/____/____ to ____/____/____