



PATIENT INFORMATION

Hepatitis C - Acute

County _____

Case name (last, first) _____
Birth date ___/___/___ Sex F M Other Alternate name _____
Phone _____ Email _____
Address type Home Mailing Other Temporary Work
Street address _____
City/State/Zip/County _____
Residence type (incl. Homeless) _____ WA resident Yes No

ACUTE EVENT ADMINISTRATION – LHJ USE

LHJ notification date ___/___/___
Investigator _____
Investigation start date ___/___/___
Investigation status Investigation not started In progress
 Complete Complete - not reportable to DOH
 Unable to complete
LHJ investigation complete date ___/___/___
LHJ case classification Confirmed Probable
 Suspect Not a case State case Contact
 Control Exposure Not classified

OUTBREAK – LHJ USE

Outbreak related Yes No Unknown
LHJ Cluster name _____ LHJ cluster # _____
REPORT SOURCE(S)
Report source _____
Report date ___/___/___
Reporter name _____
Reporter organization _____
Reporter phone _____
Diagnosis at state correctional facility Yes No Unknown
If yes, Diagnosis type Acute Chronic

COMMUNICATIONS – LHJ USE (Please document all attempts to gather information, including patient interview, provider outreach, or medical record abstraction)

OK to talk with patient Yes Never Later Unknown
Contact attempted Yes No
Date of contact attempt ___/___/___
Contact attempt type Phone call to patient Phone call to medical provider Medical record search Text to patient
 Letter to patient E-mail to patient Patient's social media Other _____
Contact attempt outcome Unable to contact Contacted and interviewed Contacted and scheduled
 Successful medical record review Left message Pending response Reinterviewed
Interviewer _____ Was patient acute, chronic, or perinatal at time of contact attempt? Unknown
Notes:

Alternative Contact

Type Friend Parent/Guardian Spouse/Partner Other _____
Name _____ Phone number _____ Email address _____

DEMOGRAPHICS

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?
Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown
What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses).
Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American
 Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk
Additional race information:
 Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____
Country of birth _____

What is your (your child's) preferred language (check one):

- Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Employed Yes No Unknown

If yes, Occupation _____ Employer/worksite _____ Zip code (occupation) _____

Student (including in daycare) Yes No Unknown

If yes, School/child care _____ Grade _____ Zip code (school) _____

CLINICAL EVALUATION

Illness duration _____ days Symptom onset date ___/___/___ Derived (indicate if onset date is inexact)

Acute diagnosis date ___/___/___

Y N Unk

Discrete onset of symptoms

Acute symptoms consistent with hepatitis (such as jaundice, vomiting, diarrhea, abdominal cramps, loss of appetite, fatigue, fever)

If diarrhea, onset date ___/___/___

Pale stool, dark urine (jaundice) If yes, onset date ___/___/___

Washington Immunization Information System (WA ISS) number _____

Documented immunity to hepatitis A (due to either vaccination or previous infection)

Yes - vaccination Yes - previous infection No Unknown

Number of doses of HAV vaccine in past 0 1 2 3 4 or more Unknown

Documented immunity to hepatitis B (due to either vaccination or previous infection)

Yes - vaccination Yes - previous infection No Unknown

Number of doses of HBV vaccine in past 0 1 2 3 4 or more Unknown

PREGNANCY

Pregnant Yes No Unknown

Date that the individual was assessed for pregnancy ___/___/___

If pregnant,

Subtype at time of this pregnancy Acute Chronic Unknown

Estimated delivery date ___/___/___

DIAGNOSTICS (Positive, Negative, Not tested, Indeterminate)

P N NT I

Antibody to hepatitis C virus (anti-HCV) Signal to cut-off ratio _____
Specimen collection date ___/___/___ Specimen accession # _____
Test laboratory _____ Test provider/facility _____

Hepatitis C antibody negative results followed by positive result collected within 12 months (test conversion) Yes No Unk

HCV RNA quantitative _____ Quantitative units I.U. I.U., log RNA copies RNA copies, log
Qualitative interpretation of quantitative result

Specimen collection date ___/___/___ Specimen accession # _____
Test laboratory _____ Test provider/facility _____

HCV RNA qualitative
Specimen collection date ___/___/___ Specimen accession # _____
Test laboratory _____ Test provider/facility _____

HCV genotype _____
Specimen collection date ___/___/___ Specimen accession # _____
Test laboratory _____ Test provider/facility _____

Liver Enzyme Tests

ALT (SGPT) Specimen collection date ___/___/___ Actual value _____
 AST (SGOT) Specimen collection date ___/___/___ Actual value _____
 BIL (Total) Specimen collection date ___/___/___ Actual value _____

CLINICAL EVALUATION - HOSPITALIZATIONHospitalized at least overnight for this illness Yes No Unknown

Hospital – facility name _____

Hospital record number _____

Admitted date ___/___/___ Discharged date ___/___/___ Length of stay _____ days

DEATH*If deceased, please change the vital status and update date of death on the Edit Person screen*Deceased Yes NoDate of death ___/___/___ Source used to verify vital status Death records Medical records Other _____Death document ID _____ Cause of death Hepatitis related Other _____**EXPOSURE****Ask about exposures 180 days to 14 days before symptom onset date. For a case classified as acute via anti-HCV or HCV RNA test conversion, in the absence of clinical criteria, 12 months to 14 days before onset date should be considered.****Travel**

	Setting 1	Setting 2	Setting 3
Travel out of	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Y N Unk Case knows anyone with similar symptoms Contact with a confirmed or suspected hepatitis C case (acute or chronic)Type of contact Household Sexual Birth Needle use Casual contact Other _____ Congregate livingType Barracks Corrections Group home Long term care School Shelter Other _____Type of corrections Jail Juvenile facility Prison Incarcerated longer than 24 hours Diabetic who lives in congregate situation (school, assisted living facility, skilled nursing home, group home) Any suspect medical or dental exposure Describe _____ Surgery (including outpatient), other medical procedures, hospitalized during exposure period

Describe _____

 Surgery (including outpatient, other than oral surgery) Other medical procedures Hospitalized during exposure period Hemodialysis IV or injection as outpatient/IV infusion or injection in outpatient setting Transfusion, blood product or transplant Date ___/___/___ Product Blood products Organs Tissue Dental work or oral surgery Employed in job with potential for exposure to human blood or body fluidsJob type Medical Dental Public safety (e.g. law enforcement/firefighter) Tattoo/piercing Other _____Frequency of direct blood or body fluids exposure Frequent (several times a week) Infrequent Unknown Other exposure to someone else's blood (including first aid) Accidental stick or puncture with sharps contaminated with blood or body fluid Ear or body piercing Body site Ears only Other _____Piercing was performed at Commercial parlor/shop Correctional facility Other _____

Address/name _____

 Received acupuncture Tattoo recipientTattoo was performed at Commercial parlor/shop Correctional facility Other _____

Body site of tattooing _____

 Shared razor, toothbrushes, or nail care items

Y N Unk

- Injected drugs not prescribed by doctor, even if only once or a few times
 Type Heroin (includes Diacetylmorphine) Cocaine Amphetamine Methamphetamine MDMA
 Ketamine PCP Anabolic steroids Opioids (prescription or non-prescription) Unknown
 Other _____
- Shared needles
- Shared other injection equipment Specify _____
- Ever used needle exchange services
- Non-injection street drug use/use street drugs Specify drugs _____
 Route of administration Inhalation Oral Transdermal Other _____
- Used drugs not prescribed by a doctor and route of administration is unknown
 Type Heroin (includes Diacetylmorphine) Cocaine Amphetamine Methamphetamine MDMA
 Ketamine PCP Anabolic steroids Opioids (prescription or non-prescription) Unknown
 Other _____
 Number of sex partners (during exposure period)
 Female _____ Male _____
- Received treatment for an STD Year of most recent STD treatment _____

ACUTE EXPOSURE SUMMARY

- Most likely exposure Illicit drugs Nonsexual close contact Sexual contact Multiple risk factors
 Other _____ Unknown
- Where did exposure probably occur In USA but not in Washington (state _____) In Washington (county _____)
 Not in USA (country _____) Unknown
- Exposure location name _____
- Exposure location address _____
- Exposure location details:

PUBLIC HEALTH ISSUES

Y N Unk

- Employed as a health care worker
- Patient in a dialysis or kidney transplant unit
- Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset
 Specify type of donation Blood products Organs Tissue (including ova or semen)
 Date ___/___/___ Agency name _____ Location _____

PUBLIC HEALTH ACTIONS

Y N Unk

- Notified blood or tissue bank (if recent donation)
- Counseled on measure to avoid transmission
- Recommended hepatitis A vaccination if at risk and susceptible
- Recommended hepatitis B vaccination if at risk and susceptible
- Notified healthcare facility if case may have transmitted to others at facility
- Notified healthcare facility if case had suspected exposure at facility
- If case is health care worker performing invasive procedures, advise strict adherence to recommended infection control practices
- Counseled patient regarding retesting in 3-6 months
- Woman counseled about pregnancy risks
- Counseled about transmission risk to baby if pregnant
- Other public health action _____
- Evaluated contacts

INSURANCE AND LINKAGE TO CARE

- Insurance status date ___/___/___
- Y N Unk**
- Patient has insurance
 Type of insurance (select all that apply)
 Medicare Medicaid VA/military
 Plan ID _____ Plan ID _____ Plan ID _____
 Employer Individual Other _____
 Plan ID _____ Plan ID _____ Plan ID _____
- Patient has provider of care for hepatitis?
- Did the patient receive medication for the type of hepatitis being reported?

If yes (patient did receive medication),

Medication name	Dose	Dose units (g, mg, ml)	Freq. per day	Other freq. unit	Duration	Duration unit (days, weeks, months)	Start date	Treatment completed	Completion date
								<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/> In progress	
								<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/> In progress	
								<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/> In progress	

If Treatment not completed, specify reason Patient financial barriers Lost to follow-up

Patient concerns about safety/adverse effects Other _____

Y N Unk

Spontaneous viral clearance

CONTACTS

	Contact 1	Contact 2	Contact 3	Contact 4
Date contact identified				
Contact's first name				
Contact's last name				
Contact's date of birth				
Contact's age (DOB unk)	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days
Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other
Contact's phone				
Contact type (select one)	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other
Method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR
OK to talk with this contact	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__
Interview category	<input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Other	<input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Other	<input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Other	<input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Other
Contact interview date				
Referred to PCP for evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Note				

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