



Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

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

Hepatitis A

County _____

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: Investigation start ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ Case complete ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

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: _____

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

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk
 Reason for testing Symptoms of acute hepatitis Elevated liver enzymes Follow-up testing for previous hepatitis marker
 Asymptomatic with risk factor Patient request Year of birth Donor screening Prenatal
 Unk Other _____

Clinical Features

Y N Unk

- Acute onset of illness**
 Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Diarrhea (3 or more loose stools within a 24 hour period) Onset date ___/___/___
 Pale stool, dark urine, yellowing of skin or eyes (jaundice) Onset date ___/___/___
 Abdominal pain or cramps
 Anorexia (loss of appetite)
 Nausea
 Vomiting
 Fatigue

Y N Unk

- Malaise
 Headache
 Any complication _____

Vaccination

Y N Unk

- Received any doses of hepatitis A vaccine Month/year of last dose ___/___ Total doses received _____
 Received immunoglobulin Month/year received ___/___

Hospitalization

Y N Unk

- Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Y N Unk

- Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
 Death certificate lists disease as a cause of death or a significant contributing condition
 Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)
 Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 15-50 days before symptom onset)

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 ____ / ____ / ____

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
- Household member traveled or lived outside the US or Canada Country (record all) _____
- Does the case know anyone else with similar symptoms or illness
Onset date, shared meals, relationship, etc. _____
- Congregate living
 - Barracks Corrections Long term care Dormitory Boarding school Camp Shelter
 - Other _____
- Child or employee in day care, nursery or preschool
- Was hepatitis A identified in facility
- Attends childcare or preschool Location/details _____
- Injected drugs not prescribed by a doctor, even if only once or a few times Describe _____
- Non-injection street drug use
- Used drugs not prescribed by a doctor but route of administration is unknown
- Failure of vaccine or post-exposure prophylaxis
- Investigating vaccine or prophylaxis failure

Food Exposure - Food exposure timeframe: 15 - 50 days prior to onset of illness. Ask about detailed food exposures only if there has been no travel exposure outside the US and Canada and no other identified risk exposure in the 15-50 days prior to the onset of illness

Sources of food IN home - During exposure timeframe did you (your child) eat foods from:

- (1) Grocery stores or supermarkets
- (2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc.)
- (3) Fish or meat specialty shops (butcher shop, etc.)
- (4) Warehouse stores (Costco, Sam's Club, etc.)
- (5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan's, NutriSystem, etc.)
- (6) Live animal market, custom slaughter facility
- (7) Small markets/mini markets (convenience stores, gas stations, etc.)
- (8) Health food stores or co-ops
- (9) Ethnic specialty markets (Mexican, Asian, Indian)
- (10) Farmers markets, roadside stands, open-air markets, food purchased directly from a farm
- (11) Other _____

Type of Business (enter number next to choices above)	Business name	Address/location

Sources of food outside home - During exposure timeframe did you (your child) eat foods from:

- | | |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> (1) Fast casual (Chipolte, Panera, etc) | <input type="checkbox"/> (10) Chinese, Japanese, Vietnamese, other Asian-style |
| <input type="checkbox"/> (2) Fast food (McDonald's, Burger King, Wendy's) | <input type="checkbox"/> (11) All-you-can-eat buffet |
| <input type="checkbox"/> (3) Sandwich shop, deli | <input type="checkbox"/> (12) Breakfast, brunch, diner, or café |
| <input type="checkbox"/> (4) Jamaican, Cuban, or Caribbean | <input type="checkbox"/> (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African |
| <input type="checkbox"/> (5) Ready-to-eat prepared food from grocery or deli | <input type="checkbox"/> (14) Any takeout from a restaurant |
| <input type="checkbox"/> (6) An event where food was served (catered event, festival, church, or community meal) | <input type="checkbox"/> (15) Healthy restaurant (vegetarian, vegan, salad-based) |
| <input type="checkbox"/> (7) Mexican, Salvadorian, other Hispanic/Latino-style | <input type="checkbox"/> (16) Salad bar at a grocery store or restaurant |
| <input type="checkbox"/> (8) Food trucks, food stalls/stands | <input type="checkbox"/> (17) Other _____ |
| <input type="checkbox"/> (9) School, hospital, senior center, or other institutional setting | |

Type of Business (enter number next to choices above)	Restaurant/venue name	Date	Time of meal (Breakfast, Brunch, Lunch, Happy Hour, Dinner, Other)	Food ordered/eaten	Address/location
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		

How many times did you eat in or get take out from restaurants or delis 1-2/month 1/week 2-4/week
 5+/week Not sure

- Y M N Unk**
 Any food sampled (grocery, warehouse stores, food court, etc.) _____
 Bivalve shellfish (oysters, clams, mussels, etc.) County/location collected or bought _____
 Any other seafood Specify _____

Water Exposure

- | | |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Y N Unk | Describe |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Source of drinking water known |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Bottled water _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Public water system _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Individual well _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Shared well _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Untreated/unchlorinated water (surface, well, lakes, streams, springs, etc.) _____ |

Sexual Exposure

- Any type of sexual contact with others during the exposure period
 Number of sexual partners during exposure period _____ Female _____ Male

Exposure and Transmission Summary

- Y N Unk**
 Epidemiologically linked to a lab positive case classified as confirmed
 Child cared for by this patient
 Household (nonsexual)
 Person giving care to this child
 Playmate
 Sexual
 Other _____

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Foodborne Waterborne Person to person Sexual Blood products IDU
 Health care associated Unk Other _____
 Describe _____

Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____
 Describe _____

Exposure summary

Suspected transmission type (check all that apply) Foodborne Waterborne Person to person Sexual
 Blood products IDU Health care associated Unk Other _____
 Describe _____

Suspected transmission setting (check all that apply) Day care/Childcare School (not college) Doctor's office
 Hospital ward Hospital ER Hospital outpatient facility Home Work College Military
 Correctional facility Place of worship Laboratory Long term care facility Homeless/shelter
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____
 Describe _____

Public Health Issues

Y N Unk

- Employed as a food handler
- Non-occupational food handling (e.g., potlucks, receptions) during contagious period
- Employed as a health care worker
- Employed in childcare or preschool
- Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis Agency and location _____
 Date ___/___/___ Specify type of donation _____
- Household member or close contact in sensitive occupation or setting (HCW, childcare, food)

Public Health Interventions/Actions

Y N Unk

- Exclude case from sensitive occupations (HCW, food, childcare) or situations (childcare) until diarrhea ceases and it is 7 days from onset of jaundice
- Notified blood or tissue bank (if recent donation)
- Commercial product implicated
- Initiate trace-back investigation
- Restaurant inspection Name/Location _____
- Public announcement recommended
- Prophylaxis of appropriate contacts recommended Date initiated ___/___/___
 Number of contacts recommended prophylaxis _____
 Number of household contacts _____
 Number of non-household contacts _____
 Number of contacts receiving prophylaxis _____
 Number of household contacts _____
 Number of non-household contacts _____
- Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING: OPTIONAL LHJ USE – DATA ENTRY IN WDRS IS OPTIONAL FOR THIS SECTION

Contagious period: 2 weeks before onset to 1 week after onset of jaundice

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
	Setting 1	Setting 2	Setting 3	Setting 4
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

NOTES

LAB RESULTSLab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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