Washington State Department of Health

Hepatitis E

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ 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

ADMINISTRATIVE

Investigator _____

LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

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

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

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 _____

REPORT SOURCE

Initial report source _____

LHJ _____

Reporter organization _____

Reporter name _____

Reporter phone _____

All reporting sources (list all that apply)

_____

_____

_____

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 _____

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	
☐	☐	☐	**Discrete onset of symptoms**
☐	☐	☐	**Acute symptoms consistent with hepatitis (vomiting, diarrhea, cramps, loss of appetite, fatigue, fever)**
☐	☐	☐	**Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**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**

Hepatitis E case required variables are in **bold.** Answers are: Yes, Maybe, No, Unknown to case

Case Name _____ LHJ Case ID _____

Predisposing Conditions

Y N Unk

☐ ☐ ☐ History of hepatitis A
☐ ☐ ☐ History of hepatitis B
☐ ☐ ☐ History of hepatitis C
☐ ☐ ☐ History of hepatitis D
☐ ☐ ☐ Documented immunity to hepatitis A (due to either vaccination or previous infection) Number of doses _____
☐ ☐ ☐ Documented immunity to hepatitis B (due to either vaccination or previous infection) Number of doses _____

Pregnancy

Pregnancy status at time of symptom onset

☐ Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
OB name, phone, address _____
☐ Postpartum (Estimated) delivery date ___/___/___
OB name, phone, address _____
☐ Neither pregnant nor postpartum ☐ Unk

Clinical Testing

Y N Unk

☐ ☐ ☐ **Aminotransferase level > 2.5 time upper limit of normal** Specify _____

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
Disposition ☐ Another acute care hospital Facility name _____
☐ Died in hospital
☐ Long term acute care facility Facility name _____
☐ Long term care facility Facility name _____
☐ Non-healthcare (home) ☐ Unk ☐ Other _____

Y N Unk

☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ 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 2-9 weeks before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ 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 _____
☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness
Onset date, shared meals, relationship, etc. _____
☐ ☐ ☐ Household or sexual contact from endemic country Country _____
☐ ☐ ☐ Any potential blood exposures (medical/dental procedures, transfusion, needle stick)
☐ ☐ ☐ Facility notified
☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates) recipient Date(s) ___/___/___
☐ ☐ ☐ Birth mother – history of viral hepatitis (if infant)
☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter
☐ Other _____
☐ ☐ ☐ Attends childcare or preschool Location/details _____
☐ ☐ ☐ Exposure to pigs/pork _____
☐ ☐ ☐ Exposure to wildlife or wild game meat _____

Food Exposure - ***Food exposure timeframe: 2 - 9 weeks prior to onset of illness. Only ask about detailed food exposures if there has been no travel exposure outside the US and Canada and no other identified risk exposure in the 2-9 weeks 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:

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

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**
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ___________		

Y M N Unk

☐ ☐ ☐ ☐ Any food sampled (grocery, warehouse stores, food court, etc.) ___________________________________

Water Exposure

Y	N	Unk		Describe
☐	☐	☐	Source of drinking water known	
☐	☐	☐	Bottled water	_____
☐	☐	☐	Public water system	_____
☐	☐	☐	Individual well	_____
☐	☐	☐	Shared well	_____
☐	☐	☐	Other	_____
☐	☐	☐	Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring)	_____

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

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	
☐	☐	☐	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_____
☐	☐	☐	Non-occupational food handling (e.g., potlucks, receptions) during contagious period
☐	☐	☐	Employed as a food handler
☐	☐	☐	Employed as a health care worker
☐	☐	☐	Employed in childcare or preschool

If needed, enter detailed information in the Transmission Tracking Questions Package

Public Health Interventions/Actions

Y	N	Unk	
☐	☐	☐	Notified blood or tissue bank (if recent donation)
☐	☐	☐	Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

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

Case Name _____ LHJ Case ID _____

	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)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

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

NOTES

LAB RESULTS

Lab 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 ☐ Pending
Test 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 document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____