Hepatitis C – Chronic, long

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

ADMINISTRATIVE

Investigator _______________ LHJ Case ID ____________
LHJ notification date ___/___/___
LHJ Classification ☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ State case ☐ Contact
☐ Control ☐ Exposure ☐ Not classified
Investigation status ☐ Investigation not started
☐ In progress ☐ Complete
☐ Complete - not reportable to DOH
☐ Unable to complete
Investigation start date ___/___/___
Investigation complete date ___/___/___
Record complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID __________Cluster Name ______________

DEMOGRAPHICS

Age _______ ☐ 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 ______________________________
Country of birth ______________________________
Primary language ______________________________
Interpreter needed ☐ Yes ☐ No ☐ Unk
Employed ☐ Yes ☐ No ☐ Unk
Occupation ______________________________
Employer/worksite ______________ Work zip code _______
Student/Day care ☐ Yes ☐ No ☐ Unk
School/childcare______________________
Grade ______________________ School zip code _______

REPORT SOURCE

Report source ____________________________
Report date ___/___/___
Reporter organization ______________________________
Reporter name ______________________________
Reporter phone ______________________________

COMMUNICATIONS

Interview performed ☐ Yes
Date ___/___/___ Interviewer _______________

Interview performed ☐ No
Reason ☐ Lost to follow-up ☐ Refused ☐ Deceased
☐ Out of jurisdiction ☐ Language barrier ☐ Other _________

Alternate contact ☐ Friend ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other ____________________
Contact name ______________________________ Contact phone ______________________________

CLINICAL EVALUATION

Chronic diagnosis date ___/___/___
Reason(s) for initial screening ☐ Prenatal screening ☐ Follow-up testing for previous marker of viral hepatitis ☐ DOB 1945-1965
☐ Blood/organ donor screening ☐ Elevated liver enzymes
☐ **Symptoms of acute hepatitis (vomiting, diarrhea, abdominal pain, anorexia, nausea or fever)**
☐ Asymptomatic with risk factors ☐ Other ______________________________
Setting of initial screening ☐ Primary care clinic ☐ ID/GI/liver clinic ☐ OB/GYN clinic ☐ Emergency room/urgent care
☐ Hospital ☐ Rehab facility ☐ Syringe exchange ☐ Jail/prison ☐ Non-clinical community site
☐ Other ______________________________

Insurance and Linkage to Care
Insurance status date ___/___/___ Patients has insurance ☐ Yes ☐ No ☐ Unk
Type of insurance ☐ Medicare ☐ Medicaid ☐ VA/military ☐ Employer ☐ Individual ☐ Other ____________________

Y N Unk
☐ ☐ ☐ Was patient referred for care
☐ ☐ ☐ If yes, Patient seen or has appointment for medical management of HCV Date of last appointment ___/___/___
Primary care provider ☐ Yes ☐ No Specialist ☐ Yes ☐ No

If no, Primary reason ☐ Deceased ☐ Incarcerated ☐ Patient declined, due to financial barriers (e.g., no insurance)
☐ Patient declined, perceived as unnecessary ☐ Appropriate provider not known
☐ App. provider known, inaccessible to patient ☐ Unk ☐ Other ________________________

☐ ☐ ☐ Did the patient receive medication for the type of hepatitis being reported
If yes,

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
								☐Y ☐N ☐Unk ☐ In progress	
								☐Y ☐N ☐Unk ☐ In progress	
								☐Y ☐N ☐Unk ☐ In progress	

If Treatment not completed, Specify reason ☐ Patient financial barriers ☐ Lost to follow-up
☐Patient concern about safety/adverse effects Other ___________________________________

☐ ☐ ☐ If no Medication, Was treatment recommended but not started
☐ ☐ ☐ If yes, Reason not started ☐ Appropriate provider not known ☐ App. provider known, inaccessible to patient
☐ Patient concerns about safety/adverse effects ☐ Patient financial barriers
☐ Patient perceives as unnecessary ☐ Treatment prescribed, set to begin
☐ Other ___________________________________

☐ ☐ ☐ Achieved sustained virological response (SVR)
SVR post-treatment time point ☐ 12 weeks ☐ 24 weeks ☐ Other ___________________________________

Vaccination History

Washington Immunization Information System (WA IIS) number ________________________
Documented immunity to hepatitis A (due to either vaccination or previous infection)
☐ Yes – vaccination ☐ Yes – previous infection ☐ No ☐ Unk
Number of doses of HAV vaccine in past _______
Documented immunity to hepatitis B (due to either vaccination or previous infection)
☐ Yes – vaccination ☐ Yes – previous infection ☐ No ☐ Unk
Number of doses of HBV vaccine in past _______

Comorbidities and Screening

Y N Unk
☐ ☐ ☐ Patient ever tested for HBV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐Other
☐ ☐ ☐ Patient ever tested for HIV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐Other
☐ ☐ ☐ Diabetes Diagnosis date ___/___/___
☐ ☐ ☐ Cirrhosis Diagnosis date ___/___/___
☐ ☐ ☐ Decompensated cirrhosis Diagnosis date ___/___/___
☐ ☐ ☐ Ever diagnosed with liver cancer Diagnosis date ___/___/___
☐ ☐ ☐ Liver transplant Diagnosis date ___/___/___
☐ ☐ ☐ Renal dialysis Diagnosis date ___/___/___
☐ ☐ ☐ Chronic kidney disease Diagnosis date ___/___/___

Liver Staging

Y N Unk
☐ ☐ ☐ Patient ever staged
Staging method ☐ APRI score ☐ ARFI ☐ Biopsy ☐ Fib-4 ☐ FibroSURE ☐ Imaging (e.g. ultrasound, CT, MRI)
☐ Liver elastography (fibroscan) ☐ Other ___________________________________
Date completed ___/___/___
Location (name of facility) ___________________________________
Fibrosis stage __________
Results/notes

Pregnancy (at time of report)

Y N Unk
☐ ☐ ☐ Pregnant (*If No/Unk, skip to Clinical)*
Estimated delivery date ___/___/___ OB name ___________________________________
OB phone ____________ OB address ___________________________________
☐ ☐ ☐ Complications during pregnancy ___________________________________

Laboratory 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 ____________________________
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 _______

Hospitalization and Death
Y N Unk
☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ____________________________________
Admit date ___/___/___ Discharge date ___/___/___ Length of stay _______ days
Hospital record number ____________________

If deceased, please change the vital status and update date of death on the Edit Person screen
Deceased ☐ Y ☐ N ☐ Unk
Death date ___/___/___
Cause of death ☐ Hepatitis related ☐ Other

EXPOSURES (If not otherwise specified report exposure information over the lifetime)
Chronic Exposure Information
Y N Unk
☐ ☐ ☐ Received clotting factor concentrates When ☐ Before 1987 ☐ 1987 or later
☐ ☐ ☐ Received blood products When ☐ Before 1992 ☐ 1992 or later
☐ ☐ ☐ Received solid organ transplant When ☐ Before 1992 ☐ 1992 or later
☐ ☐ ☐ Other organ or tissue transplant recipient Date ___/___/_____
☐ ☐ ☐ Long term hemodialysis
☐ ☐ ☐ Employed in job with potential for exposure to human blood or body fluids
Job 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 ☐ Unk
☐ ☐ ☐ Accidental stick or puncture with sharps contaminated with blood or body fluid
☐ ☐ ☐ History of occupational needle stick or splash
☐ ☐ ☐ Ever had a finger stick/prick blood sugar test
☐ ☐ ☐ Ear or body piercing Body site ☐ Ears only ☐ Other __________________________________
Piercing was performed at ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other ________________________
Address/name ____________________________________
☐ ☐ ☐ Tattoo recipient
Tattoo was performed at ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other __________________________
☐ ☐ ☐ Ever received acupuncture
☐ ☐ ☐ History of incarceration
☐ ☐ ☐ Birth mother has history of hepatitis C infection
☐ ☐ ☐ Born outside US Country ____________________________________ Number of years in the US _______
☐ ☐ ☐ Contact with confirmed or suspected hepatitis C case (acute or chronic)
Type of contact ☐ Household (non-sexual) ☐ Injection drug user ☐ Multiple contact types ☐ Sexual
☐ Other ____________________________________
Approximate number of lifetime sex partners _______
Number of sex partners _______ Female _______ Male _______ Transgender
☐ ☐ ☐ Received treatment for an STD Year of most recent STD treatment _______

☐ ☐ ☐ Non-injection street drug use/use street drugs
Specify drugs ___________________________________
Route of administration ☐ Inhalation ☐ Oral ☐ Transdermal
☐ ☐ ☐ Ever 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 ☐ Prescription opioid ☐ Unk ☐ Other ___________________
☐ ☐ ☐ Ever shared needles/other injection equipment
☐ ☐ ☐ Ever shared other injection equipment Specify ____________________________________
☐ ☐ ☐ Ever used needle exchange services
☐ ☐ ☐ Patient used injection drugs in the past 3 months

Exposure Summary

Most likely exposure
☐ Acupuncture ☐ Blood product ☐ Body piercing (except ears) ☐ Chronic hemodialysis ☐ Close contact
☐ Clotting factor ☐ Incarceration ☐ Injection drug use ☐ In job with potential blood or body fluid exposure
☐ New or risk sexual partner ☐ Organ transplant ☐ Perinatal transmission ☐ Tattoo ☐ Multiple risk factors
☐ Unk ☐ Other ___________________________________

Where did exposure probably occur ☐ In Washington – county _____________ ☐ Other state ______________
☐ Not in US - country ______________ ☐ Unk

Exposure details

☐ No risk factors or exposures could be identified

Public Health Issues

Y N Unk
☐ ☐ ☐ Patient aware of hepatitis support agencies (e.g., Hepatitis Education Project)
☐ ☐ ☐ Recent blood products, organs or tissue (Including ova or semen) donation

Public Health Actions

Y N Unk
☐ ☐ ☐ Recommended confirmatory testing
☐ ☐ ☐ Counseled on importance of regular healthcare to monitor liver health
☐ ☐ ☐ Counseled on avoidance of liver toxins (e.g., alcohol)
☐ ☐ ☐ Recommend hepatitis A vaccination
☐ ☐ ☐ Recommend hepatitis B vaccination
☐ ☐ ☐ Counseled on measure to avoid transmission
☐ ☐ ☐ Counseled to not donate blood products, organs or tissues
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Counseled about transmission risk to baby if pregnant
☐ ☐ ☐ Reinforced use of universal precautions, if health care worker
☐ ☐ ☐ Counseled on harm reduction and places to access clean syringes, if current IDU
☐ ☐ ☐ Provided contact information for hepatitis support agencies
☐ ☐ ☐ Provided patient education materials about HCV
☐ ☐ ☐ Provided options for access to health care
☐ ☐ ☐ Provided information on alcohol/substance abuse treatment
☐ ☐ ☐ Other public health action ___________________________________

Y N Unk
☐ ☐ ☐ Evaluated contacts *Go to the Contacts Question Package to enter information about each contact*

OPTIONAL LHJ USE - DATA ENTRY IN WDRS IS OPTIONAL FOR THIS SECTION

	Contact 1	Contact 2	Contact 3	Contact 4
Date contact identified				
Existing person	☐ Found ☐ Not found, add new ☐ Not enough info	☐ Found ☐ Not found, add new ☐ Not enough info	☐ Found ☐ Not found, add new ☐ Not enough info	☐ Found ☐ Not found, add new ☐ Not enough info
Contact first name				
Contact last name				
Birth date				
Age	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days
Sex	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk	☐F ☐M ☐FTM ☐MTF ☐Transgender – unspec. ☐Refused ☐Other ☐Unk
Phone				
Contact type (select **one**)	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple

	☐ Other:	☐ Other:	☐ Other:	☐ Other:
OK to talk with this contact:	☐Yes ☐Never ☐Later ☐Unk	☐Yes ☐Never ☐Later ☐Unk	☐Yes ☐Never ☐Later ☐Unk	☐Yes ☐Never ☐Later ☐Unk
Method of communication (select **one**)	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐Mail ☐In-person ☐Text ☐Email ☐Accessed EMR
Contact interview date				
Referred to PCP for evaluation	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional LHJ ID				
Optional WAIIS number				
Optional EMR number				
Optional Address				
Optional Pregnant	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional Interpreter	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional Investigator				

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