Washington State Department of HEALTH

Hepatitis C – Chronic, long

County

PATIENT INFORMATION

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 – LHJ USE

Investigator _____

LHJ notification date ___/___/___

LHJ case 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 ___/___/___

LHJ investigation complete date ___/___/___

LHJ record complete date ___/___/___

Outbreak related ☐ Yes ☐ No ☐ Unknown

LHJ cluster name _____ LHJ cluster number _____

DEMOGRAPHICS

Current gender ☐ Male ☐ Female ☐ Other ☐ Declined to answer ☐ 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: _____

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) _____

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)

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 INFORMATION SOURCE

Type ☐ Friend ☐ Parent/guardian ☐ Spouse/partner ☐ Other _____
Name _____
Phone number _____
Email address _____

CLINICAL EVALUATION

Chronic diagnosis date ___/___/___
Chronic – Reason(s) for Initial Screening (select all that apply
☐ Symptoms of acute hepatitis (vomiting, diarrhea, abdominal pain, anorexia, nausea, or fever)
☐ Asymptomatic with risk factors ☐ Asymptomatic without risk factors ☐ Prenatal screening
☐ Follow-up testing for previous marker of viral hepatitis ☐ Blood/organ donor screening ☐ Elevated liver enzymes
☐ High risk exposure ☐ 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 ___/___/___

Y N Unk

☐ ☐ ☐ Patient has insurance
Type of insurance (select all that apply)
☐ Medicare Plan ID _____ ☐ Medicaid Plan ID _____ ☐ VA/military Plan ID _____
☐ Employer Plan ID _____ ☐ Individual Plan ID _____ ☐ Other _____ Plan ID _____

☐ ☐ ☐ Was patient referred for care?
☐ ☐ ☐ If yes, Patient seen or has appointment for medical management of HCV
Primary care provider ☐ Yes ☐ No Specialist ☐ Yes ☐ No Date of last appointment ___/___/___
If no, Primary reason ☐ Incarcerated ☐ Patient declined, due to financial barriers (e.g. no insurance)
☐ Patient declined, perceived as unnecessary ☐ Appropriate provider not known
☐ Appropriate provider known, inaccessible to patient ☐ Unknown ☐ Other _____

Y N Unk

☐ ☐ ☐ 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
								☐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 concerns about safety/adverse effects Other _____

☐ ☐ ☐ If no (patient did not receive medication), Was treatment recommended but not started

If yes (treatment recommended but not started), Reason not started ☐ Appropriate provider not known ☐ Appropriate 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 ☐ 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 ☐ Unk

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

COMORBIDITIES AND SCREENING

Y N Unk

☐ ☐ ☐ Patient ever tested for HBV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

☐ ☐ ☐ Patient ever tested for HIV Date last test ___/___/___ Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

☐ ☐ ☐ 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 procedure was completed ___/___/___

Location (i.e. name of facility where procedure was performed) _____

Fibrosis stage _____

Results/notes:

PREGNANCY (at time of report)

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 ___/___/___

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 _____
☐ BIL (Total) Specimen collection date ___/___/___ Actual value _____

HOSPITALIZATION AND DEATH

Hospitalized at least overnight for this illness ☐ Yes ☐ No ☐ Unknown
Hospital – facility name _____
Admitted date ___/___/___ Discharged 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 ☐ Yes ☐ No
Date of death ___/___/___
Cause of death ☐ Hepatitis related ☐ Other _____

CHRONIC EXPOSURES (If not otherwise specified report exposure information over the lifetime)

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 bodily fluids
Job type ☐Medical ☐Dental ☐Public safety (e.g. law enforcement/firefighter) ☐Tattoo/piercing ☐Other _____
Frequency of direct blood or body fluids ☐Frequent (several times a week) ☐Infrequent ☐Unknown
☐ ☐ ☐ 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 _____ Address/name _____
Body piercing was performed at ☐Commercial parlor/shop ☐Correctional facility ☐Other _____
☐ ☐ ☐ 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 US _____
☐ ☐ ☐ Contact with confirmed or suspected hepatitis C case (acute or chronic)
Type of contact ☐Sexual ☐Household (non-sexual) ☐Needle use ☐Birth ☐Casual contact ☐Other _____

Approximate number of lifetime sex partners ☐0 ☐1 ☐2-5 ☐6-10 ☐11-20 ☐>20 ☐Unknown
Gender of sex partners ☐Male - Number _____ ☐Female (Number _____) ☐Transgender (Number _____)

☐ ☐ ☐ Received treatment for an STD
Year of most recent STD treatment _____

Y N Unk

☐ ☐ ☐ Ever injected drugs not prescribed by a doctor, even if only once or a few times

Injection drug use type (check all that apply) ☐Heroin (includes Diacetylmorphine) ☐Cocaine ☐Amphetamine ☐Methamphetamine ☐MDMA ☐Ketamine ☐PCP ☐Opioids (RX or non-RX) ☐Anabolic steroids ☐Unknown ☐Other _____

Ever shared needles ☐Yes ☐No ☐Unknown

Ever shared other injection equipment ☐Yes_____ ☐No ☐Unknown

Ever used needle exchange services ☐Yes ☐No ☐Unknown

☐ ☐ ☐ Non-injection street drug use/use street drugs

Specify drug(s) _____

Route of administration ☐Inhalation ☐Oral ☐Transdermal ☐Other _____

☐ ☐ ☐ Used drugs not prescribed by a doctor and route of administration is unknown

Type (check all that apply) ☐Heroin (includes Diacetylmorphine) ☐Cocaine ☐Amphetamine ☐Methamphetamine ☐MDMA ☐Ketamine ☐PCP ☐Opioids (prescription or non-prescription) ☐Anabolic steroids ☐Unknown ☐Other _____

☐ ☐ ☐ Patient used injection drugs in the past 3 months

EXPOSURE SUMMARY – populate Most likely exposure even if unknown

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

☐ Unknown ☐ Other _____

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

☐ ☐ ☐ 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 _____

CONTACTS

Y N Unk
☐ ☐ ☐ Evaluated contacts

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

	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)	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days	☐Yrs ☐Mos ☐Days
Gender	☐M ☐F ☐MTF ☐FTM ☐Transgender – unspec. ☐Declined ☐Unk ☐Other	☐M ☐F ☐MTF ☐FTM ☐Transgender – unspec. ☐Declined ☐Unk ☐Other	☐M ☐F ☐MTF ☐FTM ☐Transgender – unspec. ☐Declined ☐Unk ☐Other	☐M ☐F ☐MTF ☐FTM ☐Transgender – unspec. ☐Declined ☐Unk ☐Other
Contact's phone				
Contact type (select one)	☐ Sexual ☐ Household ☐ Needle use ☐ Birth ☐ Casual contact ☐ Other _____	☐ Sexual ☐ Household ☐ Needle use ☐ Birth ☐ Casual contact ☐ Other _____	☐ Sexual ☐ Household ☐ Needle use ☐ Birth ☐ Casual contact ☐ Other _____	☐ Sexual ☐ Household ☐ Needle use ☐ Birth ☐ Casual contact ☐ Other _____
OK to talk with this contact:	☐ Yes ☐ Never ☐ Unk ☐ Later – date __/__/__	☐ Yes ☐ Never ☐ Unk ☐ Later – date __/__/__	☐ Yes ☐ Never ☐ Unk ☐ Later – date __/__/__	☐ Yes ☐ Never ☐ Unk ☐ Later – date __/__/__
Method of contact (select one)	☐Phone ☐Fax ☐In-person ☐Mail ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐In-person ☐Mail ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐In-person ☐Mail ☐Text ☐Email ☐Accessed EMR	☐Phone ☐Fax ☐In-person ☐Mail ☐Text ☐Email ☐Accessed EMR
Contact interview date				
Referred to PCP for evaluation	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Note				

(NOT REQUIRED) HCV CONTINUUM OF CARE – LHJ USE

Stage on the HCV continuum (select all that apply)

☐ HCV antibody positive
Antibody date: ___/___/___

☐ Not an HCV case (RNA negative)
RNA negative date: ___/___/___

☐ HCV confirmed (RNA positive)
RNA positive date ___/___/___

☐ Linked to HCV care
Linked to care date: ___/___/___

☐ HCV treatment
Treatment date: ___/___/___

☐ Cured/SVR
Cured date: ___/___/___

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