Washington State Department of Health

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

ADMINISTRATIVE

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

Outbreak related ☐ Yes ☐ No
LHJ Cluster name _____Cluster # _____

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 _____
Translator 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

Symptom onset date ___/___/___ ☐ Derived Illness duration _____ days 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, yellowing of skin or eyes (jaundice)** Onset date ___/___/___

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 _____

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 _____

Hospitalization and Death

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____

Hospital record number _____

Admit date ___/___/___ Discharge date ___/___/___ Length of stay _____ days

Y N Unk

☐ ☐ ☐ Died of this illness

If deceased, please change the vital status and update date of death on the Edit Person screen

Death date ___/___/___ Death document ID _____

Source used to verify vital status ☐ Death records ☐ Medical records ☐ Other _____

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 _____

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 _____

Alanine Aminotransferase (ALT) >200 IU/L ☐ Yes ☐ No ☐ Unk

EXPOSURES (Ask about exposures 14-180 days 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 ___/___/___

Y N Unk

☐ ☐ ☐ Case knowns 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 living

Type ☐ Barracks ☐ Corrections ☐ Group home ☐ Long term care ☐ School ☐ Shelter

☐ Other _____

Type of corrections ☐ Jail ☐ Juvenile facility ☐ Prison

☐ ☐ ☐ Incarcerated longer than 24 hours

Y N Unk

☐ ☐ ☐ 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 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
☐ ☐ ☐ 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 recipient Body site _____
Tattoo was performed at ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other _____
☐ ☐ ☐ Shared razor, toothbrushes, or nail care items
☐ ☐ ☐ Non-injection street drug use/use street drugs Specify drugs _____
Route ☐ Inhalation ☐ Oral ☐ Transdermal ☐ Other _____
☐ ☐ ☐ 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) ☐ Unk
☐ Other _____
☐ ☐ ☐ Shared needles
☐ ☐ ☐ Shared other injection equipment Specify _____
☐ ☐ ☐ Ever used needle exchange services
☐ ☐ ☐ Patient used injection drugs in the past 6 months
Number of sex partners (during exposure period)
Female _____ Male _____
☐ ☐ ☐ Received treatment for an STD Year of most recent STD treatment _____

Exposure Summary

Most likely exposure ☐ Illicit drugs ☐ Medical/dental procedure ☐ Nonsexual close contact ☐ Sexual contact
☐ Multiple risk factors ☐ Unk ☐ Other _____
Where did exposure probably occur ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk
Exposure location name _____
Exposure location address _____
Exposure details

☐ No risk factors or exposures could be identified

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
Type of donation ☐ Blood products ☐ Organs ☐ Tissue (including ova or semen)
Date ___/___/___
Agency name _____ Location _____

Hepatitis C-Acute case defining variables are in **bold.** Answers are: Yes, No, Unknown

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
☐	☐	☐	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 _____

Y	N	Unk	
☐	☐	☐	Evaluated contacts

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 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 ☐ Other:	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple ☐ Other:	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple ☐ Other:	☐ Household (nonsexual) ☐ Injection drug use ☐ Sexual ☐ Multiple ☐ 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
Test result – susceptible	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Prophylaxis recommended	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Received prophylaxis	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Completed prophylaxis	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Prophylaxis type - HBIG	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Prophylaxis type – Hepatitis B vaccination	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Optional LHJ ID				
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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