Washington State Department of HEALTH

Hepatitis C - Acute

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

ACUTE EVENT ADMINISTRATION – LHJ USE

LHJ notification date ___/___/___

Investigator _____

Investigation start date ___/___/___

Investigation status ☐ Investigation not started ☐ In progress
☐ Complete ☐ Complete - not reportable to DOH
☐ Unable to complete

LHJ investigation complete date ___/___/___

LHJ case classification ☐ Confirmed ☐ Probable
☐ Suspect ☐ Not a case ☐ State case ☐ Contact
☐ Control ☐ Exposure ☐ Not classified

OUTBREAK – LHJ USE

Outbreak related ☐ Yes ☐ No ☐ Unknown

LHJ Cluster name _____ LHJ cluster # _____

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)

OK to talk with patient ☐ Yes ☐ Never ☐ Later ☐ Unknown

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 Contact

Type ☐ Friend ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other _____

Name _____ Phone number _____ Email address _____

DEMOGRAPHICS

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) _____

CLINICAL EVALUATION

Illness duration _____ days Symptom onset date ___/___/___ ☐ Derived (indicate if onset date is inexact)
Acute 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 (jaundice) If yes, onset date ___/___/___

Washington Immunization Information System (WA ISS) number _____
Documented immunity to hepatitis A (due to either vaccination or previous infection)
☐ Yes - vaccination ☐ Yes - previous infection ☐ No ☐ Unknown
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 ☐ Unknown
Number of doses of HBV vaccine in past ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐ Unknown

PREGNANCY

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 ___/___/___

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

CLINICAL EVALUATION - HOSPITALIZATION

Hospitalized at least overnight for this illness ☐ Yes ☐ No ☐ Unknown
Hospital – facility name _____
Hospital record number _____
Admitted date ___/___/___ Discharged date ___/___/___ Length of stay _____ days

DEATH

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

Deceased ☐ Yes ☐ No
Date of death ___/___/___ Source used to verify vital status ☐ Death records ☐ Medical records ☐ Other _____
Death document ID _____ Cause of death ☐ Hepatitis related ☐ Other _____

EXPOSURE

Ask about exposures 180 days to 14 days before symptom onset date. For a case classified as acute via anti-HCV or HCV RNA test conversion, in the absence of clinical criteria, 12 months to 14 days before onset date should be considered.

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
☐ ☐ ☐ 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 ☐ Unknown
☐ ☐ ☐ 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
Tattoo was performed at ☐ Commercial parlor/shop ☐ Correctional facility ☐ Other _____
Body site of tattooing _____

☐ ☐ ☐ Shared razor, toothbrushes, or nail care items

Y N Unk

☐ ☐ ☐ 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) ☐ Unknown
☐ Other _____

☐ ☐ ☐ Shared needles

☐ ☐ ☐ Shared other injection equipment Specify _____

☐ ☐ ☐ Ever used needle exchange services

☐ ☐ ☐ Non-injection street drug use/use street drugs Specify drugs _____
Route of administration ☐ Inhalation ☐ Oral ☐ Transdermal ☐ Other _____

☐ ☐ ☐ Used drugs not prescribed by a doctor and route of administration is unknown
Type ☐ Heroin (includes Diacetylmorphine) ☐ Cocaine ☐ Amphetamine ☐ Methamphetamine ☐ MDMA
☐ Ketamine ☐ PCP ☐ Anabolic steroids ☐ Opioids (prescription or non-prescription) ☐ Unknown
☐ Other _____

Number of sex partners (during exposure period)
Female _____ Male _____

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

ACUTE EXPOSURE SUMMARY

Most likely exposure ☐ Illicit drugs ☐ Nonsexual close contact ☐ Sexual contact ☐ Multiple risk factors
☐ Other _____ ☐ Unknown

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

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

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

☐ ☐ ☐ If case is health care worker performing invasive procedures, advise strict adherence to recommended infection control practices

☐ ☐ ☐ 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 _____

☐ ☐ ☐ Evaluated contacts

INSURANCE AND LINKAGE TO CARE

Insurance status date ___/___/___

Y N Unk

☐ ☐ ☐ Patient has insurance
Type of insurance (select all that apply)

☐ Medicare	☐ Medicaid	☐ VA/military
Plan ID _____	Plan ID _____	Plan ID _____
☐ Employer	☐ Individual	☐ Other _____
Plan ID _____	Plan ID _____	Plan ID _____

☐ ☐ ☐ Patient has provider of care for hepatitis?

☐ ☐ ☐ 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 _____

Y N Unk

☐ ☐ ☐ Spontaneous viral clearance

CONTACTS

	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 _____
Method of contact	☐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
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 __/__/__
Interview category	☐Basic ☐Enhanced ☐Other	☐Basic ☐Enhanced ☐Other	☐Basic ☐Enhanced ☐Other	☐Basic ☐Enhanced ☐Other
Contact interview date				
Referred to PCP for evaluation	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Note				

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