Utah Public Health
Name of Local Health Department
Address of Local Health Department
Phone: ***(xxx) xxx-xxxx*** *Confidential Fax* ***(xxx) xxx-xxxx***
Date:

IN PARTNERSHIP WITH UTAH'S **PUBLIC HEALTH** DEPARTMENTS

HEPATITIS C, PERINATAL (≤36 MONTHS AGE)

CONFIDENTIAL CASE REPORT

Form should be completed for children born to HCV pos. gestational parent

PATIENT INFORMATION

Child's Last Name: Child's First Name: MI:

Gestational Parent Name: Guardian Name:

Address: City: State:

County: Zip: Date of Public Health Report:

Phone #1 (H/W/C): Phone #2 (H/W/C):

DEMOGRAPHIC INFORMATION

Race: *(check all that apply)*
□ White □ Black/African American □ Other Race, specify____________
□ Asian □ American Indian/Alaskan Native □ Native Hawaiian or Pacific Islander

Ethnicity: □ Hispanic
□ Not Hispanic
□ Other/Unknown

Birth sex: *(circle one)*
M F U

Date of birth: _____/_____/_____
Place of birth: □ U.S. □ Other_________________

Age:___________

CLINICAL INFORMATION

Why was patient tested? (*check all that apply*):
□ Symptoms of acute hepatitis
□ Evaluation of elevated liver enzymes
□ Follow-up testing for previous marker of viral hepatitis
□ Gestational parent HCV positive
□ Unknown
□ Other: ___________________________________

Symptom Onset Date: _____/_____/_____ Clinician Name: Clinician Phone #:

Diagnosis date: _____/_____/_____
Is/was patient symptomatic? □ Yes □ No □ Unknown
□ Discrete onset □ Anorexia □ Nausea □ Malaise
□ Fever □ Vomiting □ Abdominal pain □ Headache
□ Diarrhea
At diagnosis, was the patient:
- Jaundiced? □ Yes □ No □ Unknown
- Hospitalized for hepatitis? □ Yes □ No □ Unknown

Did patient die from hepatitis? □ Yes □ No □ Unknown
- Date of death: _____/_____/_____

Does patient have provider of care/pediatrician? □ Yes □ No □ Unknown

List doctor name/facility:______________________

Laboratory Testing:

	Test Result:		Test Date:
HBsAg	Pos.	Neg.	_____/_____/_____
HBsAb	Pos.	Neg.	_____/_____/_____
Total anti-HBc	Pos.	Neg.	_____/_____/_____
HBeAg	Pos.	Neg.	_____/_____/_____
HBV Genotype: ________			_____/_____/_____
IgM anti-HBc	Pos.	Neg.	_____/_____/_____
Hep B NAT	Pos.	Neg.	_____/_____/_____
Anti-HCV	Pos.	Neg.	_____/_____/_____
HCV NAT	Pos.	Neg.	_____/_____/_____
HCV Genotype: ________			_____/_____/_____
Anti-HDV	Pos.	Neg.	_____/_____/_____

Were chemistries done? □ Yes □ No □ Unknown

Name of laboratory: ______________________________ Date collected: _____/_____/_____

ALT (SGPT) results: ________________ Upper limit normal:__________________

AST (SGOT) results: ________________ Upper limit normal:__________________

Bilirubin results: ____________________ Upper limit normal:__________________

PATIENT HISTORY

Was **gestational parent*** positive with any of the following tests prior to or at time of delivery?

- HCV Antibody □ Yes □ No □ Unknown Date of test: _____/_____/_____
- HCV RNA □ Yes □ No □ Unknown Date of test: _____/_____/_____
- HCV Genotype □ Yes □ No □ Unknown Date of test: _____/_____/_____

Was **gestational parent*** positive with any of the following tests after delivery?

- HCV Antibody □ Yes □ No □ Unknown Date of test: _____/_____/_____
- HCV RNA □ Yes □ No □ Unknown Date of test: _____/_____/_____
- HCV Genotype □ Yes □ No □ Unknown Date of test: _____/_____/_____

Please complete full HCV Acute & Chronic case report form for gestational parent.

For infant, list date of earliest positive test result for the following:

- HCV Antibody _____/_____/_____
- HCV RNA _____/_____/_____ HCV Genotype _____/_____/_____

REPORTING INFORMATION

Reporter's name: ____________________________________ Phone number: ______________________________

Reporter's agency: ___________________________________ Date reported to public health: ____/_____/_____

LHD Investigator: Phone: Date submitted to UDOH: _____/_____/_____

LHD Reviewer:

LHD Case classification: *(check one)*

□ Confirmed □ Probable □ Suspect □ Unknown □ Resolved □ Pending □ Out of state □ Not a case

EDUCATION

a) Has healthcare provider been contacted to provide education on testing recommendations in children under 36 months?

• If yes, please provide details:

• If no, why?

b) Has gestational parent /guardian received education on testing recommendations in children under 36 months?

• If yes, please provide details:

• If no, why?

d) If known, what is the outcome of gestational parent to baby transmission (vertical transmission)?

- Baby infected with HCV
- Baby not infected with HCV
- Pending further testing