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, PREGNANCY EVENT CONFIDENTIAL CASE REPORT

Form should be completed for HCV positive gestational parent

MOTHER'S INFORMATION

Last Name: First Name: MI:

Preferred Name (Nickname): Maiden:

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: _____/_____/_____ Age:_____
Place of birth: □ U.S. □ Other_____

CLINICAL INFORMATION

Why was patient tested? (*check all that apply*):
- □ Symptoms of acute hepatitis
- □ Symptomatic patient with reported risk factors
- □ Evaluation of elevated liver enzymes
- □ Follow up testing for previous marker of viral hepatitis
- □ Year of birth (1945-1965)
- □ Received/receiving HCV positive transplant
- □ Symptomatic patient without risk factors
- □ Prenatal screening
- □ Blood/organ donor screening
- □ 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: _____/_____/_____

Was patient aware he/she had viral hepatitis prior to lab testing? □ Yes □ No □ Unknown
Does patient have provider of care for hepatitis? □ Yes □ No □ Unknown
Does patient have diabetes? □ Yes □ No □ Unknown
- Diabetes diagnosis date: _____/_____/_____

Laboratory Testing:

	Test Result:		Test Date:
Total anti-HAV	Pos.	Neg.	_____/_____/_____
IgM anti-HAV	Pos.	Neg.	_____/_____/_____
HBsAg	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.	_____/_____/_____
IgM anti-HEV	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

Is gestational parent positive with any of the following tests prior to or at time of pregnancy?

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

Pregnancy Information:

Pregnancy number: _____ Expected delivery date: _____/_____/_____ Actual delivery date: _____/_____/_____

Expected delivery facility:_____ Actual delivery facility:_____

Physician/OBGYN: _____ Parent insured? □ Yes □ No □ Unknown Details:_____

Infant insured? □ Yes □ No □ Unknown Details:_____

Outcome:

□ Delivered □ Delivered twins/multiple infants □ False positive pregnancy

□ Miscarried/pregnancy terminated □ Left state before delivery □ Lost to follow-up □ Unknown

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 gestational parent /guardian received 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 HCV treatment for self?

- If yes, please provide details:

- If no, why?