Utah Public Health
Name of Local Health Department
Address of Local Health Department

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

HEPATITIS C (ACUTE & CHRONIC) | CONFIDENTIAL CASE REPORT

CONTACT INFORMATION

Prefix: (Mr. Mrs. Miss Ms. Etc.) 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): Case ID:

DEMOGRAPHIC INFORMATION

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

Ethnicity: □ Hispanic
□ Not Hispanic
□ Other/Unknown

Sex: *(Circle one)*
M F U

Date of birth: _____/_____/_____ Age:_____ (years)
Place of Birth: □ U.S. □ Other_____

CLINICAL INFORMATION

Why was patient tested (check all that apply):

□ Symptoms of acute hepatitis
□ Screening asymptomatic patient with reported risk factors
□ Evaluation of elevated liver enzymes
□ Follow up testing for previous marker of viral hepatitis
□ Year of birth (1945-1965)
□ Screening asymptomatic patient with no risk factors
□ Prenatal screening
□ Blood/organ donor screening
□ Received/receiving HCV positive transplant
□ Unknown
□ Other: _____

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

Diagnosis date: _____/_____/_____
Is patient symptomatic? □ Yes □ No □ Unknown
□ Acute 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

Was the patient pregnant? □ Yes □ No □ Unknown
- Due date: _____/_____/_____

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 a 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:_____

Diagnosis (*check all that apply*):
□ Acute hepatitis A □ Acute hepatitis C □ Chronic HBV infection □ Perinatal HBV infection
□ Acute hepatitis B □ Acute hepatitis E □ Chronic HCV infection □ Perinatal HCV infection

PATIENT HISTORY (ACUTE CASES ONLY)

During the **2 weeks- 6 months** prior to onset of symptoms or seroconversion was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection? _____/_____/_____ to _____/_____/_____
□ Yes □ No □ Unknown
If yes, select type of contact and list contact information on contact form:
Sexual □ Yes □ No □ Unknown
Household (non-sexual) □ Yes □ No □ Unknown
Other:_____ □ Yes □ No □ Unknown

During the **2 weeks- 6 months** prior to onset of symptoms or seroconversion did the patient:
- Undergo hemodialysis? □ Yes □ No □ Unknown
- Have an accidental stick with a needle/object contaminated w/ blood? □ Yes □ No □ Unknown
- Receive blood or blood products (transfusion)? □ Yes □ No □ Unknown
  - If yes, when? _____/_____/_____
- Receive any IV infusions and/or injections in the outpatient setting? □ Yes □ No □ Unknown
- Have other exposure to someone else's blood? □ Yes □ No □ Unknown
  - Specify:_____

During the **2 weeks- 6 months** prior to onset of symptoms or seroconversion: _____/_____/_____ to _____/_____/_____
- Was the patient employed in a medical or dental field involving direct contact with human blood? □ Yes □ No □ Unknown
  - If yes, frequency of blood contact?
    □ Frequent (several times weekly) □ Infrequent
- Was the patient employed as a public safety worker (fire fighter, law enforcement, or correctional officer) having direct contact with blood? □ Yes □ No □ Unknown
  - If yes, frequency of blood contact?
    □ Frequent (several times weekly) □ Infrequent
- Did the patient receive a tattoo? □ Yes □ No □ Unknown
  - Where was the tattooing performed? (select all that apply)
    □ Commercial parlor/shop □ Correctional facility □ Other_____

Ask both of the following questions regardless of the patient's gender.
In the **6 months** before symptom onset/seroconversion, how many: _____/_____/_____ to _____/_____/_____
- Male sex partners did the patient have? _____
- Female sex partners did the patient have? _____

Was the patient **EVER** treated for a sexually transmitted disease? □ Yes □ No □ Unknown
- If yes, in what year was the most recent treatment? _____

During the **2 weeks- 6 months** prior to onset of symptoms/seroconversion did the patient:
- Inject drugs not prescribed by a doctor? □ Yes □ No □ Unknown
- Use street drugs, but not inject? □ Yes □ No □ Unknown

Did the patient have a negative HCV antibody test within 6 months to a positive test? □ Yes □ No □ Unknown
- If yes, verified test date: _____/_____/_____

During the **2 weeks- 6 months** prior to onset of symptoms or seroconversion: _____/_____/_____ to _____/_____/_____

- Did the patient have any part of his/her body pierced (other than ear)? □ Yes □ No □ Unknown
  - Where was the piercing performed? (*check all that apply*)
    □ Commercial parlor/shop □ Correctional facility □ Other_____
- Did the patient have dental work or oral surgery? □ Yes □ No □ Unknown
- Did the patient have surgery? (other than oral surgery) □ Yes □ No □ Unknown
- Was the patient: (*check all that apply*)
  - Hospitalized? □ Yes □ No □ Unknown
  - A resident of a long-term care facility? □ Yes □ No □ Unknown
  - Incarcerated for longer than 24 hours? □ Yes □ No □ Unknown
    - If yes, what type of facility (*check all that apply*)
      □ Prison □ Jail □ Juvenile facility

During his/her lifetime, was the patient **EVER** incarcerated for longer than 6 months?
□ Yes □ No □ Unknown

- If yes,
  - What year was his/her most recent incarceration? _____
  - For how long? _____ (months)

Has the patient received medication for the type of hepatitis being reported? □ Yes □ No □ Unknown

PATIENT HISTORY (CHRONIC CASES ONLY)

- Did the patient receive a blood transfusion prior to 1992? □ Yes □ No □ Unknown
- Did the patient receive an organ transplant prior to 1992? □ Yes □ No □ Unknown
- Did the patient receive clotting factor concentrates produced prior to 1987? □ Yes □ No □ Unknown
- Was the patient ever on long-term hemodialysis? □ Yes □ No □ Unknown
- Has the patient ever injected drugs not prescribed by a doctor, even if only once or a few times? □ Yes □ No □ Unknown
- How many sex partners has the patient had (approximate lifetime)? _____
- Was the patient ever incarcerated? □ Yes □ No □ Unknown
- Was the patient ever treated for a sexually transmitted disease? □ Yes □ No □ Unknown
- Was the patient ever a contact of a person who had hepatitis? □ Yes □ No □ Unknown
  - If yes, type of contact:
    Sexual □ Yes □ No □ Unknown
    Household (non-sexual) □ Yes □ No □ Unknown
    Other:_____ □ Yes □ No □ Unknown
- Was the patient ever employed in a medical or dental field involving direct contact with human blood? □ Yes □ No □ Unknown

VACCINE HISTORY

Has patient ever received a hepatitis B containing vaccine? □ Yes □ No □ Unknown

Has patient ever received a hepatitis A containing vaccine? □ Yes □ No □ Unknown

REPORTING INFORMATION

Reporter's name: _____ Phone: _____

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

CASE CONTACTS

List any high-risk contacts during the 2 weeks-6 months prior to onset of symptoms or seroconversion.

Last Name:____ First Name:________________________________ MI:________

Preferred Name (Nickname):___________________________ Maiden Name:_______________________________________

Address:____ City:________________________ State:______ Zip Code:_______

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

Email address or other contact information:____

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify___________________________________

Last Name:____ First Name:________________________________ MI:________

Preferred Name (Nickname):___________________________ Maiden Name:_______________________________________

Address:____ City:________________________ State:______ Zip Code:_______

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

Email address or other contact information:____

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify___________________________________

Last Name:____ First Name:________________________________ MI:________

Preferred Name (Nickname):___________________________ Maiden Name:_______________________________________

Address:____ City:________________________ State:______ Zip Code:_______

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

Email address or other contact information:____

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify___________________________________

Last Name:____ First Name:________________________________ MI:________

Preferred Name (Nickname):___________________________ Maiden Name:_______________________________________

Address:____ City:________________________ State:______ Zip Code:_______

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

Email address or other contact information:____

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify___________________________________

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