

VIRAL HEPATITIS A OR E CASE REPORT



Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
www.lapublichealth.org/acd

Census tract: _____ VCMR ID: _____

Patient name-last		first	middle initial	Date of Birth	Age	Sex
Address- number, street			City	State	ZIP Code	
Telephone number Home ()	Work ()	Cell ()		Country of Birth		
Race (check one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____				Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		
If Asian/Pacific Islander, check one: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____						
Occupation or school (give city/zip code)			Homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>	Sensitive Occupation/Situation (S.O.S)? Yes <input type="checkbox"/> No <input type="checkbox"/>		

PRESENT ILLNESS

Diagnosis date: _____ Was patient jaundiced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, start date: _____ Did patient have symptoms other than jaundice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, onset date: _____ What symptoms? _____	Was the patient hospitalized for hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, admit date: _____ Facility/Hospital Name: _____ If female: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, due date: _____ Did patient die from hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, date of death: _____	Medical Record No. _____
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VACCINE HISTORY

	Yes	No	Unk	If Yes, Date dose given. 1 st Dose	2 nd Dose	3 rd Dose
hepatitis A vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
hepatitis B vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

DIAGNOSTIC TESTS (Check all tests performed and attach laboratory results.)

Reason for testing: (Check all that apply) <input type="checkbox"/> Symptoms of acute hepatitis <input type="checkbox"/> Evaluation of elevated liver enzymes <input type="checkbox"/> Exposure to case <input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis <input type="checkbox"/> Routine screening of patient (physical exam, MD visit, pre-op) <input type="checkbox"/> Unknown <input type="checkbox"/> Other Specify: _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Laboratory results:</td> <td style="width: 10%; text-align: center;">Pos</td> <td style="width: 10%; text-align: center;">Neg</td> <td style="width: 10%; text-align: center;">No Test/Unk</td> </tr> <tr> <td>Total antibody to hepatitis A virus (total anti-HAV)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> 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Liver enzyme results at time of diagnosis:
 Test Result Date: _____ ALT (SGPT) _____ AST (SGOT) _____ Bilirubin _____

PUBLIC HEALTH NURSING INITIAL ASSESSMENT AND EVALUATION

If acute hepatitis (check here), please complete the remainder of this form. See Page 3 for acute hepatitis A definition.
 If **NOT** acute hepatitis (check here), please go to **Final Diagnosis** section and complete.

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

EPIDEMIOLOGIC RISK FACTORS (Continued)

During the exposure period (2-7 weeks prior to onset): If YES, ask patient when and where and record in Remarks section. Yes No Unk

Did the patient know or have contact with anyone with hepatitis A virus infection? (suspected or laboratory-confirmed)

If Yes, was the contact a: (check all that apply)

- Sexual partner
- Household member (non-sexual)
- Drug sharing partner
- Child cared for by this patient
- Babysitter of this patient
- Kind of drug shared? _____
- Playmate
- Other _____

FOOD HISTORY (During Exposure Period 2-7 WEEKS PRIOR TO ONSET)

Name (restaurants, bars, food stores, group meals, bakeries, etc.)	Location (Address, City)	Dates Exposed	Foods Eaten

REMARKS (Please explain any YES answers in Epidemiologic Risk Factor section. Please sign your notes.)

Suspected Source

Educated patient according to B-73 on the following:

Mode of Transmission:

- Fecal-Oral
- Sexual

Prevention:

- Household Contacts
- Vaccine
- Personal Hygiene
- Immunoglobulin (IG)

Other:

FINAL DIAGNOSIS

- Acute Hepatitis A Unable to locate (UTL)
- False Hepatitis A Could not confirm: Explain why? _____
- Acute Hepatitis E

Acute Hepatitis A - Case Definition:

- 1) An acute illness with discrete onset of symptoms **AND**
- 2) Jaundice **OR** elevated serum aminotransferase levels **AND**
- 3) IgM anti-HAV positive

Investigator's name (print)	Investigator's signature	Date	Telephone number ()
Health District	Supervisor signature	Area Medical Director's signature	