State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐ Preliminary ☐ Final

HEPATITIS E
CASE REPORT

Please note: *Completion of the clinical and laboratory sections of the following voluntary case report form is encouraged for all instances meeting criteria for confirmed or probable acute Hepatitis E infection in order to standardize reporting. In addition, prompt interview of case-patients* ***without*** *international travel during their incubation period is encouraged to improve the accuracy of recall of possible vehicles of infection. Jurisdictions that choose to use this form should maintain the form at the local jurisdiction to be provided to the State's Infectious Diseases Branch staff if the patient is identified as having domestically-acquired acute Hepatitis E infection. For jurisdictions participating in CalREDIE, entry into the CalREDIE form or scanning and uploading into the CalREDIE filing cabinet will facilitate surveillance analysis and investigations of domestically-acquired cases. Please do not fax or send hard copy of the form to the State unless requested.*

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ *Years* ☐ *Months* ☐ *Days*

Address Number & Street - Residence	*Apartment/Unit Number*

City/Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone/Pager*	*Work/School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work/School Location	*Work/School Contact*

Gender
☐ Male ☐ Female ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 8)	*Other Describe/Specify*

Occupation (see list on page 8)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other:_____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 8)
☐ African-American/Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other:_____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian
- ☐ Other:_____

☐ White
☐ Other:_____
☐ Unk

*Comment: self-identity or self-reporting
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

Reasons for testing (check all that apply)
☐ Symptoms of acute hepatitis ☐ Exposure to case
☐ Evaluation of elevated liver enzymes ☐ Unknown ☐ Other:_____

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unk	Onset Date (mm/dd/yyyy)	Onset Time (hh:mm)	Specify AM/PM ☐ AM ☐ PM	Duration of Acute Symptoms (days)

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Fever					Onset date of jaundice (mm/dd/yyyy)
Fatigue					
Loss of appetite					
Abdominal pain					
Diarrhea				Max. number of stools in 24-hr period	Onset date of diarrhea (mm/dd/yyyy)
Clay stools (white or gray)					
Yellow skin or eyes					Onset date of jaundice (mm/dd/yyyy)
Dark urine					

Other signs / symptoms (specify)

PAST MEDICAL HISTORY

Does the patient have a history of liver disease? ☐ Yes ☐ No ☐ Unk	If Yes, please specify condition(s):
Does the patient have any other underlying medical conditions? (i.e., renal disease, diabetes, immune compromising conditions) ☐ Yes ☐ No ☐ Unk	If Yes, specify medical conditions(s):
Is the patient on immunosuppressive therapy? ☐ Yes ☐ No ☐ Unk	If Yes, specify medication(s):
Does the patient drink alcohol? ☐ Yes ☐ No ☐ Unk	If Yes, how many servings of alcohol in a typical week?

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	Was patient hospitalized? ☐ Yes ☐ No ☐ Unk	If Yes, how many total hospital nights?

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

First three letters of patient's last name: | | | |

OUTCOME

Outcome?	If Survived,	Date of Death (mm/dd/yyyy)	Died of Hepatitis?
☐ Survived ☐ Died ☐ Unk	Survived as of _____(mm/dd/yyyy)		☐ Yes ☐ No ☐ Unk

LABORATORY INFORMATION

HEPATITIS E DIAGNOSTIC TESTS (required)

	Positive	Negative	Unk/Not done	mm/dd/yyyy	
HEV PCR	☐	☐	☐	____/___/_____	If positive, specimen site:_____
Anti-HEV IgM	☐	☐	☐	____/___/_____	
Anti-HEV IgG acute serum	☐	☐	☐	____/___/_____	If positive, titer:_____
Anti-HEV IgG convalescent serum	☐	☐	☐	____/___/_____	If positive, titer:_____

LIVER ENZYME LEVELS AT DIAGNOSIS

		mm/dd/yyyy
ALT [SGPT] Result: _____	Upper limit of normal:_____	___/___/_____
AST [SGOT] Result:_____	Upper limit of normal:_____	___/___/_____
Bilirubin:_____		___/___/_____

OTHER VIRAL HEPATITIS DIAGNOSTIC TESTS

	Positive	Negative	Unk/Not done	mm/dd/yyyy		Positive	Negative	Unk/Not done	mm/dd/yyyy
HAV antibody, IgM	☐	☐	☐	____/___/_____	HBV DNA	☐	☐	☐	____/___/_____
HAV antibody, total	☐	☐	☐	____/___/_____	HCV Antibody	☐	☐	☐	____/___/_____
HB surface antibody	☐	☐	☐	____/___/_____	HCV RNA	☐	☐	☐	____/___/_____
HB surface antigen	☐	☐	☐	____/___/_____	HDV Antibody	☐	☐	☐	____/___/_____
HB core antibody	☐	☐	☐	____/___/_____					

Other: _____

_____

_____

TRAVEL HISTORY

During the 3 months prior to illness, did patient travel **outside county of residence**? ☐ Yes ☐ No ☐ Unk *(If Yes, specify all locations and dates below.)*	During the 3 months prior to illness, did patient travel **outside the USA?** ☐ Yes ☐ No ☐ Unk **(If No, please fill out Epidemiological Information)**
During the 3 months prior to illness, did any household members travel **outside the USA?** ☐ Yes ☐ No ☐ Unk *(If Yes, specify all locations and dates below.)*	During the 3 months prior to illness, did any guests visiting from **outside the USA** stay in your household? ☐ Yes ☐ No ☐ Unk *(If Yes, specify locations and dates below or frequency for recurrent travel.)*
During the 3 months prior to illness, did the patient consume any food or beverage brought by an individual from **outside the USA?** ☐ Yes ☐ No ☐ Unk *(If Yes, specify all locations and dates below.)*	*Please specify travel details below.*

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Relationship to Contact	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

If case-patient traveled outside the USA at any time during the 3 months prior to onset, no additional exposure history necessary.

First three letters of patient's last name: | | | |

Infection Timeline

Incubation period: 15-60 days (mean, 40 days)
Infectious period: Most likely to occur 1 week before onset of illness until 2 weeks after jaundice onset

Enter date of onset in onset box*
Count backward and forward to determine probable exposure and communicable periods

EXPOSURE PERIOD COMMUNICABLE PERIOD

Days from onset:	*-60 days*	*-7 days*	***ONSET****	*+14 days*
Calendar dates:	___/___/_____ *(mm/dd/yyyy)*	___/___/_____ *(mm/dd/yyyy)*	___/___/_____ *(mm/dd/yyyy)*	___/___/_____ *(mm/dd/yyyy)*

**onset of jaundice or onset of symptoms if not jaundiced*

EPIDEMIOLOGIC INFORMATION

ONLY COMPLETE THIS SECTION IF CASE PATIENT DID NOT TRAVEL OUTSIDE THE USA DURING THE THREE MONTHS PRIOR TO ILLNESS ONSET

BLOOD AND ORGAN DONATION

Did patient donate blood during the incubation period? ☐ Yes ☐ No ☐ Unk *Date:* ____/____/_____	*Did patient donate an organ during the incubation period?* ☐ Yes ☐ No ☐ Unk *Date:* ____/____/_____
Did patient receive a blood transfusion during the incubation period? ☐ Yes ☐ No ☐ Unk *Date:* ____/____/_____	*Did patient receive an organ transplant during the incubation period?* ☐ Yes ☐ No ☐ Unk *Date:* ____/____/_____

FOOD HISTORY

DID THE PATIENT EAT ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	*Yes*	*No*	*Unk*	*If Yes, Specify as Noted*		
Shellfish				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unk	*Where purchased*
Pork liver				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unk	*Where purchased*
Meat from wild swine (boar or other non-commercial pork product)				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unk	*Where purchased*
Venison (deer or elk meat)				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unk	*Where purchased*
Other offal (e.g. kidneys, heart; Specify animal type and organ)				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unk	*Where purchased*
Other game (e.g. pheasant, rabbit; whether hunted by case-patient or another person)				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unk	*Where purchased*

FOOD HISTORY - GROCERIES

WHERE DID PATIENT SHOP FOR ANY FOOD ITEMS LISTED ABOVE? (INCLUDE FARMER'S MARKETS, DELIS, SWAP MEETS, ETC.)

Store / Location 1	*Address / Cross-streets*	
	City	*State*
Store / Location 2	*Address / Cross-streets*	
	City	*State*
Store / Location 3	*Address / Cross-streets*	
	City	*State*

(continued on page 5)

First three letters of patient's last name: | | | |

FOOD HISTORY - OUTSIDE HOME

*Did patient consume any of the foods **listed above** prepared outside of the home during the incubation period?* ☐ Yes ☐ No ☐ Unk	*If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed below.*

FOOD HISTORY - OUTSIDE HOME - DETAILS

Name of Place 1	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	
Name of Place 2	*Location (city, state)*	*Date (mm/dd/yyyy)*
	Items Consumed	

ANIMAL EXPOSURES

DID THE PATIENT HAVE ANY OF THE FOLLOWING ANIMAL EXPOSURES DURING THE INCUBATION PERIOD?

Animal Exposures	*Yes*	*No*	*Unk*	*Type(s) of Animals*	*Animal ill?*	*Setting/Location*	*Date (mm/dd/yyyy)*
Rodent					☐ Yes ☐ No ☐ Unk		
Pig or boar					☐ Yes ☐ No ☐ Unk		
Other livestock (e.g., cows, sheep, goats)					☐ Yes ☐ No ☐ Unk		
Farms					☐ Yes ☐ No ☐ Unk		
Animal exhibits (e.g., petting zoos, fairs)					☐ Yes ☐ No ☐ Unk		
Other animal exposures of interest					☐ Yes ☐ No ☐ Unk		

WATER EXPOSURES

DID THE PATIENT HAVE ANY OF THE FOLLOWING WATER EXPOSURES DURING THE INCUBATION PERIOD?

Water Source	*Yes*	*No*	*Unk*	*Activity*	*Location*	*Date (mm/dd/yyyy)*
Natural: rivers, lakes, oceans, etc.						
Artificial: swimming pools, water parks, fountains, etc.						
Other water exposures of interest						

Source of household drinking water (check all that apply)

☐ Municipal tap water ☐ Filtered tap water ☐ Private well water ☐ Untreated water ☐ Bottled water

If bottled, specify: _____

First three letters of patient's last name: | | | |

ILL CONTACTS					
Any contacts with similar illness (including household contacts)? ☐ Yes ☐ No ☐ Unk			*If Yes, specify details below.*		
ILL CONTACTS - DETAILS					
Name 1	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unk
Name 2	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unk
Name 3	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unk
Name 4	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unk

NOTES / REMARKS

First three letters of patient's last name: | | | |

REPORTING AGENCY			
Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*
First Reported By ☐ Clinician ☐ Laboratory ☐ Other (specify):_____		*Health education provided?* ☐ Yes ☐ No ☐ Unk	*Restriction / clearance needed?* ☐ Yes ☐ No ☐ Unk

EPIDEMIOLOGICAL LINKAGE	
Epi-linked to known case? ☐ Yes ☐ No ☐ Unk	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION
Case Classification (see case definition below) ☐ Confirmed ☐ Probable ☐ Not a case

OUTBREAK	
Part of known outbreak? ☐ Yes ☐ No ☐ Unk	*If Yes, extent of outbreak:* ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unk ☐ Other (specify):_____

Mode of Transmission	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*
☐ Point source ☐ Person-to-person ☐ Unk ☐ Other:_____			

STATE USE ONLY
State Case Classification ☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

CASE DEFINITION

HEPATITIS E (2016)

CLINICAL CRITERIA

Evidence of discrete onset of (1) acute illness (e.g. fever, malaise, fatigue) AND (2) liver damage, either clinical (e.g. anorexia, nausea, jaundice, dark urine, right upper quadrant tenderness) or biochemical (elevated alanine aminotransferase (ALT) level above ten times the upper limit of normal).

LABORATORY CRITERIA

Confirmatory criteria:

- *Detection of HEV RNA by nucleic acid amplification testing (PCR) in any clinical specimen,* **OR**
- *Detection of a four-fold increase in quantitative HEV IgG antibody in acute and convalescent serum specimens,* **OR**
- *Detection of HEV IgM antibody in serum AND negative tests for other causes of acute viral hepatitis including negative hepatitis A virus IgM antibody, hepatitis B virus surface antigen, hepatitis C virus RNA, and hepatitis D virus IgM antibody.*

Probable criteria:

Detection of HEV IgM antibody in serum in the absence of other tests described above.

CASE DEFINITION

Confirmed case:

A case meeting clinical criteria AND confirmatory laboratory criteria.

Probable case:

- *A case meeting clinical criteria AND probable laboratory criteria,* **OR**
- *A case meeting clinical criteria who is a close contact to a confirmed case of HEV.*

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor/actress
- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - server
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown