State of California-Health and Human Services Agency

CDPH California Department of PublicHealth

ACUTE HEPATITIS B OR C CASE REPORT

Mail to: California Department of Public Health
Immunization Branch
850 Marina Bay Parkway
Richmond, CA 94804-6403
OR Fax to: (510) 620-3949

CASE IDENTIFICATION AND DEMOGRAPHICS

PATIENT'S NAME *Last* *First* *Middle initial*

DOB *(month/day/year)* / /

AGE *(enter age and check one)* ☐Days ☐Weeks ☐Months ☐Years

DATE OF REPORT / /

ADDRESS NUMBER & STREET

CITY/TOWN

STATE

ZIP CODE

COUNTY

COUNTRY OF BIRTH ☐USA ☐OTHER: _____

HOME PHONE ( )

OTHER PHONE (specify) _____ ( )

GENDER ☐F ☐M ☐FTM ☐MTF ☐Other ☐Unknown

PREGNANT? ☐Yes ☐No ☐Unknown

PATIENT'S OCCUPATION/SETTING ☐Hospital/Medical/Dental ☐Correctional facility ☐Public safety ☐Other:_____ ☐Long-term care facility ☐Unknown

EMPLOYER NAME AND ADDRESS:

ETHNICITY *(check one)* ☐Hispanic/Latino ☐Non-Hispanic/ Non-Latino ☐Unknown

RACE *(check all that apply)* ☐Black/African-American ☐Native American/Alaskan Native ☐White ☐Unknown ☐Other:_____

☐Asian*: Please specify:* ☐Asian Indian ☐Cambodian ☐Chinese ☐Filipino ☐Hmong ☐Japanese ☐Korean ☐Laotian ☐Thai ☐Vietnamese ☐Other Asian: _____

☐Pacific Islander: *Please specify:* ☐Native Hawaiian ☐Guamanian ☐Samoan ☐Other Pacific Islander: _____

REASONS FOR TESTING *(check all that apply)* ☐Symptoms of acute hepatitis ☐Evaluation of liver enzymes ☐Exposure to case ☐Prenatal screening ☐Unknown ☐Other: _____

PHYSICIAN NAME

CMR **ID**

PHYSICIAN PHONE ( )

CDPH ID

CLINICAL AND DIAGNOSTIC DATA

SYMPTOMATIC? ☐Yes ☐No ☐Unknown
If No, report as chronic case or seroconversion

SYMPTOMS *(check all that apply)* ☐Jaundice ☐Anorexia ☐Clay stools ☐Dark urine ☐Abdominal pain ☐Fatigue ☐Diarrhea ☐Other: _____

DIED OF HEPATITIS? ☐Yes ☐No ☐Unknown
IF YES, DATE OF DEATH / /

ONSET OF SYMPTOMS / /

DIAGNOSIS DATE (test date) / /

HOSPITALIZED? ☐Yes ☐No ☐Unknown

HOSPITAL NAME

ADMIT DATE / /

DISCHARGE DATE / /

HEPATITIS B VACCINE HISTORY *Date Unknown* *Vaccine Type*

☐Dose #1 Date __/__/____ ☐ _____
☐Dose #2 Date __/__/____ ☐ _____
☐Dose #3 Date __/__/____ ☐ _____
☐None ☐Unknown

If ≤18 years, why not vaccinated?_____

Tested for anti-HBs within 1-2 months after the last dose? ☐Yes ☐No

If yes, was serum anti-HBs ≥ 10mIU/ml? ☐Yes ☐No

HEPATITIS A VACCINE HISTORY *Date Unknown* *Vaccine Type*

☐Dose #1 Date __/__/____ ☐ _____
☐Dose #2 Date __/__/____ ☐ _____
☐None ☐Unknown

LIVER ENZYME LEVELS AT DIAGNOSIS

ALT [SGPT] Result _____ __/__/____
AST [SGOT] Result _____ __/__/____
Bilirubin Result _____ __/__/____

LAB TESTS	*Positive*	*Negative*	*Unknown*	*Month/Day/Year*
Anti-HCV	☐	☐	☐	__/__/____
HCV RNA	☐	☐	☐	__/__/____
HCV Genotype	☐	☐	☐	__/__/____
HCV Antigen*	☐	☐	☐	__/__/____
IgM anti-HAV	☐	☐	☐	__/__/____
Anti-HAV total	☐	☐	☐	__/__/____
HBsAg	☐	☐	☐	__/__/____
IgM anti-HBc	☐	☐	☐	__/__/____
Anti-HBs	☐	☐	☐	__/__/____
Anti-HBc total	☐	☐	☐	__/__/____
HBeAg	☐	☐	☐	__/__/____
HBV DNA	☐	☐	☐	__/__/____
Anti-HDV	☐	☐	☐	__/__/____
Anti-HEV	☐	☐	☐	__/__/____
Other _____	☐	☐	☐	__/__/____

DIAGNOSIS

☐ **CONFIRMED ACUTE HEPATITIS B:** Acute illness with discrete symptom onset and at least one item each from columns I, II, and III

I	II	III
- Jaundice - ALT >100IU/L	- HBsAg positive	- IgM anti-HBc positive (if done)

☐ **HEPATITIS B SEROCONVERSION:** Negative HBsAg result with a positive HBV result in the following 6 months; may be asymptomatic. Indicate date of last HBsAg negative result on page 2.

☐ **PROBABLE ACUTE HEPATITIS C:** Acute illness with discrete symptom onset and at least one item each from columns I , II, and IV

☐ **CONFIRMED ACUTE HEPATITIS C:** Acute illness with discrete symptom onset and at least one item each from columns I, III, and IV

I	II	III	IV
- Jaundice - ALT >200IU/L	- Anti-HCV positive	- NAT for HCV RNA positive (including genotype) - HCV antigen*	- No report of test conversion (documented negative anti-HCV, HCV NAT or HCV antigen* result followed by a positive result)

☐ **HEPATITIS C SEROCONVERSION:** Negative Anti-HCV, HCV antigen* or HCV RNA result with a positive HCV result in the following 12 months; may be asymptomatic. Indicate date of last negative HCV result on page 2.

* When and if a test for HCV antigen(s) is approved by FDA and available.

INCUBATION PERIOD

Hepatitis B: range 45 to 160 days, average 90 days.
Hepatitis C: range 2 weeks to 6 months, average 6-7 weeks.
Incubation period: ____/____/_____ to ____/____/_____

RISK FACTOR INFORMATION ***(list details below, including dates, locations, types of procedures, etc.)***

During incubation period did patient have:	*Yes*	*No*	*Unknown*	*Dates*	*Facility*
Contact of confirmed or suspected case of hepatitis B/C ☐Household ☐Sexual ☐Injection ☐Occupation ☐Other _____	☐	☐	☐	/ /	
Accidental stick/puncture with an object contaminated with blood	☐	☐	☐	/ /	
Other exposure to someone's blood	☐	☐	☐	/ /	
Receipt of blood or blood products (transfusion)	☐	☐	☐	/ /	
Hemodialysis	☐	☐	☐	/ /	
Prior hospitalization	☐	☐	☐	/ /	
Outpatient procedure (i.e., colonoscopy, endoscopy)	☐	☐	☐	/ /	
Injections or infusions prescribed by doctor	☐	☐	☐	/ /	
Dental work or oral surgery	☐	☐	☐	/ /	
Surgery other than oral surgery	☐	☐	☐	/ /	
Finger stick/blood draw in home or clinic	☐	☐	☐	/ /	
Podiatric procedures	☐	☐	☐	/ /	
Chemotherapy treatment	☐	☐	☐	/ /	
Acupuncture treatment	☐	☐	☐	/ /	
Body piercing	☐	☐	☐	/ /	
Piercing location ☐Commercial parlor ☐Jail/Prison ☐Other					
Tattoo	☐	☐	☐	/ /	
Tattooing location ☐Commercial parlor ☐Jail/Prison ☐Other					
Manicure or pedicure	☐	☐	☐	/ /	
Other treatment or cosmetic procedure that penetrated the skin	☐	☐	☐	/ /	
Injected drug not prescribed by a doctor	☐	☐	☐	/ /	
Used non-injected street drugs	☐	☐	☐	/ /	
Incarceration	☐	☐	☐	/ /	
One or more male sex partners	☐	☐	☐	/ /	
How many? _____					
One or more female sex partners	☐	☐	☐	/ /	
How many? _____					
Treatment for a sexually-transmitted disease	☐	☐	☐	/ /	
Ever donated blood (or was denied due to hepatitis infection)	☐	☐	☐	/ /	
Indication of recent seroconversion:					
Negative HBsAg result within 6 months prior to HBV diagnosis	☐	☐	☐	/ /	
Negative Anti-HCV result within 12 months prior to HCV diagnosis	☐	☐	☐	/ /	

RISK FACTOR DETAILS:

Risk Details:	Facility Details (Dates, Addresses, Procedures):

SUSPECTED SOURCE

☐Drug Use ☐Sexual Exposure ☐Occupational Exposure ☐Healthcare Exposure ☐ Wound/Accident
☐Other, Specify:

☐Unknown

COMPLETED BY	**LHD**	**PHONE** ( )	**DATE COMPLETED** / /	**REPORT TO CDPH** / /