County of Los Angeles **Public Health**

VIRAL HEPATITIS A CASE REPORT

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

Reset Form

IRIS ID: _____

PATIENT INFORMATION

Patient Name - Last	First	Middle	Date of Birth	Age

Address - Number, Street	City	State	Zip Code

Telephone Number Home	Work	Cell	Email	Country of Birth	Date of Arrival

Patient's current gender identity? (check one)
☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth? (check one)
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: _____ ☐ Prefer not to answer

Patient's sexual orientation? (check one)
☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____
☐ Don't understand the question ☐ Prefer not to answer

Patient's race or ethnicity? (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Some other race; specify: _____ ☐ Refused
If Asian or Native Hawaiian/Other Pacific Islander, specify nationalities/ethnic groups: _____

Occupation, school, and/or volunteer (city/zip code)

Homelessness? ☐ Yes ☐ No

Sensitive Occupation/Situation (S.O.S)? ☐ Yes ☐ No

CLINICAL INFORMATION

Diagnosis date: _____

Was patient jaundiced? ☐ Yes ☐ No ☐ Unknown
If Yes, start date: _____

Did patient have symptoms other than jaundice?
☐ Yes ☐ No ☐ Unknown If Yes, onset date: _____

What symptoms? (check all that apply)
☐ Abdominal Pain ☐ Dark Urine ☐ Diarrhea
☐ Anorexia ☐ Clay stools ☐ Fever
☐ Headache ☐ Nausea ☐ Vomiting
☐ Fatigue ☐ Malaise ☐ Myalgia
☐ Joint pain ☐ Other (specify): _____

Did the patient visit the emergency room for illness? ☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized for hepatitis?
☐ Yes ☐ No ☐ Unknown If Yes, add hospitalization details.

Medical Record Number

Facility/Hospital Name:

Admit date	Discharge date	Did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? ☐ Yes ☐ No ☐ Unknown

If female: Pregnant? ☐ Yes ☐ No ☐ Unknown If Yes, due date: _____

Did the patient develop fulminant hepatitis? ☐ Yes ☐ No ☐ Unknown

Did the patient die from hepatitis? ☐ Yes ☐ No ☐ Unknown If Yes, date of death: _____

VACCINE HISTORY *Look up case in CAIR and/or review other immunization records and indicate whether they received the 2 dose or 3 dose vaccine series.*

	Yes	No	Unk	If Yes, vaccine type/name	2 or 3 dose series?	1st Dose Date	2nd Dose Date	3rd Dose Date
Hepatitis A vaccine	☐	☐	☐		2 ☐ 3 ☐			
Hepatitis B vaccine	☐	☐	☐		2 ☐ 3 ☐			

If ≤18 Years and not vaccinated, specify why not vaccinated: _____

Reason for testing: (check all that apply)
☐ Symptoms of acute hepatitis
☐ Evaluation of abnormal liver biochemistries/liver function tests
☐ Exposure to case
☐ Routine screening of patient (physical exam, MD visit, pre-op)
☐ Recent international travel
☐ Unknown
☐ Other (specify): _____

LABORATORY INFORMATION *(Check all tests performed and attach laboratory results.)*

Hepatitis A Diagnostic Tests	Positive	Negative	Borderline	Not Tested	Unknown	Specimen Collection Date
Total antibody to hepatitis A virus (total anti-HAV) ……....	☐	☐	☐	☐	☐	_____
IgM antibody to hepatitis A virus (IgM anti-HAV) ……..……	☐	☐	☐	☐	☐	_____
Hepatitis A virus PCR (HAV PCR) ……..……..……	☐	☐	☐	☐	☐	_____

HAV genotype _____

Patient Name (Last, First) _____ Date of Birth _____IRIS ID: _____

LABORATORY INFORMATION – Continued *(Check all tests performed and attach laboratory results.)*

Hepatitis B Diagnostic Tests	Positive	Negative	Borderline	Not Tested	Unknown	Specimen Collection Date
Total antibody to hepatitis B core antigen (total anti-HBc) ……....	☐	☐	☐	☐	☐	_____
IgM antibody to hepatitis B core antigen (IgM anti-HBc) ……	☐	☐	☐	☐	☐	_____
Hepatitis B surface antigen (HBsAg) ……	☐	☐	☐	☐	☐	_____
Antibody to hepatitis B surface antigen (anti-HBs) ……	☐	☐	☐	☐	☐	_____
Hepatitis B e antigen (HBeAg) ……...	☐	☐	☐	☐	☐	_____
Antibody to hepatitis B e antigen (anti-HBe) ……	☐	☐	☐	☐	☐	_____
Hepatitis B Nucleic Acid Test (NAT) (HBV DNA) ……..……	☐	☐	☐	☐	☐	_____
Hepatitis C Diagnostic Tests						
Antibody to hepatitis C virus (anti-HCV) ……...	☐	☐	☐	☐	☐	_____
Hepatitis C Nucleic Acid Test (NAT) (HCV RNA) ….…….....	☐	☐	☐	☐	☐	_____
HCV genotype _____						
Other Viral Hepatitis Diagnostic Tests						
Antibody to hepatitis D virus (IgM anti-HDV) ……...	☐	☐	☐	☐	☐	_____
Hepatitis D Nucleic Acid Test (NAT) (HDV RNA) ……..……	☐	☐	☐	☐	☐	_____
Antibody to hepatitis E virus (IgM anti-HEV) ……...	☐	☐	☐	☐	☐	_____
Hepatitis E Nucleic Acid Test (NAT) (HEV RNA) ……..…….	☐	☐	☐	☐	☐	_____

Liver enzyme results at time of diagnosis:

Specimen collection date: _____ ALT (SGPT) _____ AST (SGOT) _____ Total Bilirubin _____

Peak liver enzyme results:

ALT (SGPT) _____ Specimen collection date: _____ AST (SGOT) _____ Specimen collection date: _____

Total Bilirubin _____ Specimen collection date: _____

PUBLIC HEALTH NURSING INITIAL ASSESSMENT AND EVALUATION

If acute hepatitis (check here ☐), please complete the remainder of this form. See Page 5 for acute hepatitis A definition.

If **NOT** acute hepatitis (check here ☐), please go to **Final Diagnosis** section and complete.

INFECTION TIMELINE

Incubation period: 15-50 days.
Infectious period: Transmission likely to occur 2 weeks before onset of illness until 7 days after jaundice onset (or 14 days after symptom onset if no jaundice).
Post-exposure prophylaxis: See B-73.

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

Days from onset:	**-50 days**	**-14 days**	**ONSET***	**+7 days**
Calendar dates: *(month/day/year)*				

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

CLOSE CONTACTS DURING INFECTIOUS PERIOD

(e.g., household and sexual contacts, persons using injection or non-injection drugs with the HAV-infected person, caregivers not using appropriate personal protective equipment)

Name/ Relationship to case	Age	Occupation	S.O.S. Yes	S.O.S. No	S.O.S. Unk	Prior History of Hepatitis A Vaccine	Comments (include Prophylaxis and/or Vaccine)
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		

EPIDEMIOLOGIC RISK FACTORS *(Refer to Infection Timeline above)*

During the INFECTIOUS PERIOD

	Yes	No	Unk
Was the patient employed as a food handler or SOS?	☐	☐	☐
If Yes, Did patient work while ill or in the 2 weeks prior to onset? If Yes, call ACDC immediately.	☐	☐	☐

Last day of work: _____ Dates worked during infectious period: _____

Employer/Situation: _____

Address, City: _____ Phone: _____

Job Duties: _____

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
If patient was not serologically confirmed, is there an epidemiologic link between the patient and a laboratory-confirmed hepatitis A case?	☐	☐	☐
Did the patient travel outside of Los Angeles County?	☐	☐	☐

If Yes, specify location(s) and dates of travel?

Travel Locations (city, county, state, country)	Dates of Travel	
	From	To

	Yes	No	Unk
Did any of the patient's close contacts travel outside of Los Angeles County?	☐	☐	☐

If Yes, specify location(s) and dates of travel?

Travel Locations (city, county, state, country)	Contact Name/Relation	Dates of Travel	
		From	To

	Yes	No	Unk
Was the patient a close contact of a child or employee in a nursery, day care center or preschool?	☐	☐	☐
If Yes, was there an identified hepatitis A patient in a nursery, day care center or preschool?	☐	☐	☐
Was the patient a household contact of a diapered child?	☐	☐	☐
If Yes, was the child adopted internationally?	☐	☐	☐
Was the patient suspected as being part of a common-source outbreak?	☐	☐	☐

If Yes, specify outbreak #_____

	Yes	No	Unk
Did the patient use any recreational or illicit drugs?	☐	☐	☐

If Yes, List the drugs used and route.

Drug Name	Route of Administration *(e.g.: smoked, snorted, injected, taken by mouth)*

	Yes	No	Unk
Did the patient share drugs or equipment with others?	☐	☐	☐

How many sex partners did the patient have? (Ask questions regardless of the patient's gender.)

Number of male sex partners: _____ ☐ Unknown ☐ Refused to answer

Number of female sex partners: _____ ☐ Unknown ☐ Refused to answer

Number of trans/non-binary sex partners: _____ ☐ Unknown ☐ Refused to answer

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

Was the patient homeless? ☐ ☐ ☐

If Yes, did the patient reside in any of the following places? (Check all that apply.)

Type of Place: ☐ On the street ☐ Family/friend home ☐ Shelter ☐ Correctional facility (jail, prison, juvenile detention)
☐ Drug treatment facility ☐ Psychiatric care facility ☐ Group home/Board and Care
☐ Other: Specify. _____

Name	Address, City, State, Zip Cross streets (if applicable)	Specify Dates of Stay From	To

Was the patient incarcerated in the last 12 months? ☐ ☐ ☐

If Yes, type of facility: ☐ Jail ☐ Prison ☐ Juvenile facility Date of last incarceration: _____

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 _____

Was the patient a part of known outbreak? ☐ ☐ ☐

If Yes, extent of outbreak: ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown
☐ Other: _____

FOOD HISTORY

During the EXPOSURE PERIOD (2-7 weeks prior to onset): If YES, ask about and record locations where purchased/consumed. Yes No Unk

Did the patient eat raw or undercooked shellfish? ☐ ☐ ☐

Type(s)	Brand(s)	Store/Location Name	Address/Cross-streets, City, State	Date

Did the patient eat frozen berries or other frozen fruit (including in juices/smoothies)? ☐ ☐ ☐

Type(s)	Brand(s)	Store/Location Name	Address/Cross-streets, City, State	Date

Did the patient eat fresh berries (including in juices/smoothies)? ☐ ☐ ☐

Type(s)	Brand(s)	Store/Location Name	Address/Cross-streets, City, State	Date

Did the patient eat green onions? ☐ ☐ ☐

Store/Location Name	Address/Cross-streets, City, State	Date

Patient Name (Last, First) _____ Date of Birth _____IRIS ID: _____

FOOD HISTORY – Continued

During the EXPOSURE PERIOD (2-7 weeks prior to onset): If YES, ask about and record locations where purchased/consumed.

Food Establishment Name *(restaurants, bars, food stores, group meals, bakeries, shelter, kitchen, group home, etc.)*	Location (Address, City, State)	Date(s) Exposed	Foods Eaten

Groceries *(Include farmers markets, delis, swap meets, etc.)*

Store/Location Name	Location (Address, City)

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 ☐ False Hepatitis A ☐ Unable to locate (UTL) ☐ Could not confirm: Specify. _____

Does this case meet the binational case definition? ☐ Yes ☐ No ☐ Unknown

Binational Case Definition:

Any individual with a confirmed or probable case of a notifiable infectious disease, and:

1) Who has recently traveled or lived in Mexico, or had recent contact with persons who lived or traveled in Mexico; **OR**
2) Who is thought to have acquired the infection in Mexico or have been in Mexico during the incubation period of the infection and was possibly contagious during this period; **OR**
3) Who is thought to have acquired the infection from a product from Mexico; **OR**
4) Whose case requires the collaboration of both countries for the purposes of disease investigation and control.

Acute Hepatitis A - Case Definition:

Must have the following:

1) An acute illness with discrete onset of symptoms
2) Jaundice **OR** elevated serum aminotransferase levels >200 IU/L **OR** elevated total bilirubin ≥ 3.0 mg/dL
3) IgM anti-HAV positive
4) the absence of a more likely diagnosis

OR

1) Hepatitis A RNA detected by NAT (HAV PCR/genotyping)

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