

ACUTE HEPATITIS C CASE REPORT FORM



Included below are the acceptable submission methods of this form:

- **Healthcare Providers:** Please submit this form to your local health department.
- **Local Health Jurisdictions:** Please enter this form into CalREDIE and upload a copy into the CalREDIE Electronic Filing Cabinet.
- **For Out of State Providers:** Please send via fax to (916) 636-6216 or secure email to ovhp@cdph.ca.gov.

Note: if printing this form all dates should be entered in MM/DD/YYYY format.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

Date of Birth: _____ Age (enter and check one): _____ Days Weeks Months Years

Patient's Parent/Guardian Name: _____ Primary Language: English Other: _____

Address Number & Street: _____ Apartment/Unit Number: _____

City: _____ State: _____ Zip Code: _____ County of Residence: _____

Country of Residence: U.S. Other: _____ Country of Birth: U.S. Other: _____

Date of Arrival: _____ Home Telephone: (____) _____ Cellular Phone/Pager: (____) _____

Email Address: _____ Other Electronic Communication: _____

Work/School Location (Name & Address): _____

Occupation Setting: Correctional Facility Hospital/Medical/Dental Public Safety Long Term Care Facility
 Unknown Other: _____

Specify Occupation: _____ Work/School Telephone: (____) _____

Gender: Declined to answer Female Genderqueer or non-binary Identity not listed Male
 Trans female/Transwoman Trans male/Transman Unknown

Sex Assigned at Birth: Male Female Declined to Answer Unknown

Sexual Orientation: Heterosexual or straight Gay, lesbian, or same-gender loving Bisexual Orientation not listed
 Questioning, unsure, or patient doesn't know Declined to answer Unknown

Pregnant: Yes No Unknown Estimated Delivery Date: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race (check all that apply):

American Indian or Alaska Native

Asian
 Asian-Burmese Bangladeshi Bhutanese Burmese Cambodian Chinese Filipino Hmong
 Indian Indonesian Iwo Jiman Japanese Korean Laotian Madagascar Malaysian
 Maldivian Nepalese Okinawan Pakistani Singaporean Sri Lankan Taiwanese Thai
 Vietnamese Unknown Other: _____

Black or African American

Native Hawaiian or Other Pacific Islander

Carolinian Chamorro Chuukese Fijian Guamanian Kiribati Kosraean Mariana Islander
 Marshallese Melanesian Micronesian Native Hawaiian New Hebrides Palauan Papua New Guinean
 Pohnpeian Polynesian Saipanese Samoan Solomon Islander Tahitian Tokelauan Tongan
 Yapese Unknown Other: _____

White

Other: _____

Unknown:

CLINICAL INFORMATION

REASON FOR TESTING

Reasons (check all that apply)

- Blood/Organ Donor Screening Evaluation of Liver Enzymes Exposure to Case Prenatal Screening Routine Testing
 Symptoms of Acute Hepatitis Unknown Other: _____

SIGNS AND SYMPTOMS

Symptomatic? Yes No Unknown

Symptoms? Abdominal Pain Anorexia Clay Stools Dark Urine Diarrhea Fatigue Jaundice [Onset Date: _____]
 Other: _____

HOSPITALIZATION AND HOSPITAL DETAILS

Did patient visit emergency room for illness? Yes No Unknown

Was patient hospitalized? Yes No Unknown **How many total hospital nights?** _____

During any part of the hospitalization, did patient stay in an intensive care unit or critical care unit? Yes No Unknown

Hospital Name: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Telephone: (____) _____**

Admit Date: _____ **Discharge/Transfer Date:** _____ **Medical Record Number:** _____

Discharge Diagnosis: _____

COMPLICATIONS AND OTHER SYMPTOMS

Did patient die? Yes No Lost to Follow-Up **Date of Death:** _____

LINKAGE TO CARE

Was patient linked to HCV care? Yes No Unknown **HCV Treatment Start Date:** _____

For more information on managing acute hepatitis C infection, see the AASLD HCV treatment guidelines:

<https://www.hcvguidelines.org/unique-populations/acute-infection>

VACCINATION HISTORY

Hepatitis B Vaccination History

Has the patient been immunized for hepatitis B? Yes No Unknown **Vaccine Type:** _____

If ≤ 18 Years, specify why not vaccinated? _____

Hepatitis A Vaccination History

Has the patient been immunized for hepatitis A? Yes No Unknown **Vaccine Type:** _____

LABORATORY INFORMATION

VIRAL HEPATITIS C DIAGNOSTIC TESTS

Hepatitis C Antibody (Anti-HCV)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Hepatitis C Antibody (Anti-HCV)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Hepatitis C Antibody (Anti-HCV)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Hepatitis C Ribonucleic Acid (HCV RNA)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Hepatitis C Ribonucleic Acid (HCV RNA)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Hepatitis C Ribonucleic Acid (HCV RNA)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Hepatitis C Ribonucleic Acid (HCV RNA)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

Specify HCV Genotype (if available): _____

VIRAL HEPATITIS A DIAGNOSTIC TESTS

IgM Antibody to Hepatitis A Virus (IgM anti-HAV)

Date: _____ Result: Positive Negative Pending Not Done Unknown Borderline

Total Antibody to Hepatitis A Virus (Anti-HAV Total)

Date: _____ Result: Positive Negative Pending Not Done Unknown Borderline

VIRAL HEPATITIS B DIAGNOSTIC TESTS

Hepatitis B Surface Antigen (HBsAg)

Date: _____ Result: Positive Negative Pending Not Done Unknown Borderline

IgM Antibody to Hepatitis B Core Antigen (IgM anti-HBc)

Date: _____ Result: Positive Negative Pending Not Done Unknown Borderline

Antibody to Hepatitis B Surface Antigen (Anti-HBs)

Date: _____ Result: Positive Negative Pending Not Done Unknown Borderline

Total Antibody to Hepatitis B Core Antigen (Anti-HBc total)

Date: _____ Result: Positive Negative Pending Not Done Unknown Borderline

Quantitative Hepatitis B DNA (HBV DNA Quant.)

Date: _____ Result (IU/ml): _____

Qualitative Hepatitis B DNA (HBV DNA Qual.)

Date: _____ Result: Detected Not Detected Pending Not Done Unknown

Hepatitis B Envelope Antigen (HBeAG)

Date: _____ Result: Detected Not Detected Pending Not Done Unknown Borderline

VIRAL HEPATITIS D DIAGNOSTIC TESTS

Antibody to Hepatitis Delta (Anti-HDV)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

VIRAL HEPATITIS E DIAGNOSTIC TESTS

Antibody to Hepatitis E (Anti-HEV)

Date: _____ Result: Positive Negative Indeterminate Pending Not Done Unknown

LIVER ENZYME LEVELS AT DIAGNOSIS

Alaine Transaminase [Serum Glutamic Pyruvic Transaminase] (ALT [SGPT])

Date: _____ Result: _____ Upper Limit Normal: _____

Aspartate Aminotransferase [Serum Glutamic Oxaloacetic Transaminase] (AST [SGOT])

Date: _____ Result: _____ Upper Limit Normal: _____

Bilirubin

Date: _____ Result: _____

EPIDEMIOLOGICAL INFORMATION

INCUBATION PERIOD

• Hepatitis C: range 2 weeks to 6 months, average 6-7 weeks.

• Incubation Period: _____ to _____

RISK FACTOR INFORMATION

During the incubation period, were any of the following risk factors present?	Yes	No	Unknown	Date
Contact with a confirmed or suspected case of hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, type of contact: <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Injection <input type="checkbox"/> Occupational <input type="checkbox"/> Other: _____				
Accidental stick/puncture with an object contaminated with blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other exposure to someone's blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

During the incubation period, did the patient have any of the following treatment or cosmetic procedures?	Yes	No	Unknown	Date first seen at facility	Date last seen at facility	Facility Name
Receipt of blood or blood products (transfusion)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Receipt of organ (transplant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prior hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Received outpatient procedure (i.e., colonoscopy, endoscopy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Received injection or infusions prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Oral surgery or dental work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Surgery other than oral surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Fingerstick or blood draw in home or clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Podiatric procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Chemotherapy treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Acupuncture treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
If yes, where was piercing performed?	<input type="checkbox"/> Commercial Parlor	<input type="checkbox"/> Jail or Prison	<input type="checkbox"/> Other:	_____		
Tattoo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
If yes, where was tattoo received?	<input type="checkbox"/> Commercial Parlor	<input type="checkbox"/> Jail or Prison	<input type="checkbox"/> Other:	_____		
Manicure or pedicure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other treatment or cosmetic procedure that penetrated the skin (e.g. head or neck shave)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
If yes, specify: _____						

During the incubation period, were any of the following applicable to the patient?	Yes	No	Unknown
Injection drug use not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used non-injection street drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was incarcerated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One or more male sex partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of male partners _____			
One or more female sex partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of female partners _____			
One or more trans/non-binary sex partners?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of trans/non-binary partners _____			
Ever treated for a sexually-transmitted infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever donated blood (or was denied due to hepatitis infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify year and location of last blood donation _____			
Homelessness/unstable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative Anti-HCV result within 12 months prior to HCV diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, collection date _____			
Negative HCV RNA result within 12 months prior to HCV diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, collection date _____			
Indication of recent seroconversion (see seroconversion definition on page 5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS

Suspected Source Drug Use Sexual Contact Occupational Exposure Healthcare Exposure Wound or Accident
 Organ Donor Unknown Other: _____

EPIDEMIOLOGICAL LINKAGE

Epi-Linked to known case? Yes No Unknown **Contact Name/Case #:** _____

OUTBREAK

Part of known outbreak? Yes No Unknown
If yes, extent of outbreak One CA jurisdiction Multiple CA jurisdictions Multistate International Unknown
 Other: _____

Mode of Transmission Point Source Person-to-Person Unknown Other: _____

CASE DEFINITION

- PROBABLE ACUTE HEPATITIS C:** Cases are > 36 months of age, unless known to have been exposed non-perinatally with: at least one item each from columns I, II, and III, AND with no reports available on items in column IV and V below.
- CONFIRMED ACUTE HEPATITIS C:** Cases are > 36 months of age, unless known to have been exposed non-perinatally with: one item each from column I, III, and IV OR V below (check box by HEPATITIS C SEROCONVERSION and specify type of seroconversion if true).

I	II	III	IV	V
<ul style="list-style-type: none"> • Jaundice • Peak elevated total bilirubin ≥ 3.0mg/dL • Peak elevated ALT > 200 IU/L 	<ul style="list-style-type: none"> • Anti-HCV positive 	<ul style="list-style-type: none"> • The absence of a more likely diagnosis (e.g., evidence of acute liver disease due to other causes or pre-existing chronic HCV infection) 	HCV detection test: <ul style="list-style-type: none"> • Positive nucleic acid test (NAT) for HCV RNA (including qual, quant, or genotype), OR • Positive test indicating HCV antigen* 	<ul style="list-style-type: none"> • Test seroconversion (see definition below)

- HEPATITIS C TEST SEROCONVERSION (specify type)**
 - Documented negative anti-HCV test followed within 12 months by a positive anti-HCV test
 - Documented negative anti-HCV test followed within 12 months by a positive HCV detection test
 - Documented negative HCV detection test without a prior diagnosis of hepatitis C followed within 12 months by a positive HCV detection test
 - Reinfection: At least 2 sequential documented negative HCV detection tests at least 12 weeks apart in someone with a prior diagnosis of hepatitis C followed by a positive HCV detection test§

* At present, no HCV antigen tests are approved by the US Food and Drug Administration (FDA).

§ Number and timing of sequential negative HCV RNA results required to meet the reinfection case definition may change as the CDC guidelines evolve.

CASE INVESTIGATION

BINATIONAL INVESTIGATION

Binational Case Definition

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

- who has recently traveled or lived in Mexico, or had recent contact with persons who lived or traveled in Mexico; or
- 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
- who is thought to have acquired the infection from a product from Mexico; or
- whose case requires the collaboration of both countries for the purposes of disease investigation and control.

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

NOTES

CASE INVESTIGATION

Completed by: _____ Local Health Jurisdiction: _____
 Telephone: (____) _____ Date Completed: _____ Date Reported: _____