



Infectious Disease Control Unit, Texas Department of State Health Services

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Viral Hepatitis Case Track Record

FINAL STATUS: NBS PATIENT ID#: (Check all that apply)

- Confirmed Acute hepatitis A Chronic
Confirmed Acute hepatitis B NAC
Confirmed Acute hepatitis C

Patient's Name: last first
Address:
City: County: Zip:
Region: Phone:
Parent/Guardian:
Physician: Phone:
Address:

Reported By:
Agency:
Phone:
Date:
Report Given to:
Organization:
Phone:

DEMOGRAPHICS: DATE OF BIRTH: AGE: SEX: Male Female Unknown
RACE: White Black Asian Native Hawaiian or Other Pac. Islander Am. Indian or Alaska Native Unknown Other:
HISPANIC: Yes No Unknown
If female, is patient currently pregnant? Yes No Unknown Obstetrician's name, address, and phone #:
If yes, estimated date and location of delivery: / /

Was the patient hospitalized for this illness?
Hospitalized at:
Admitted: / / Discharged: / /
Duration of Stay days

- Reason for testing:
Evaluation of elevated liver enzymes
Follow-up testing (prior viral hepatitis maker)
Screening of asymptomatic patient w/ risk factors
Screening of asymptomatic patient w/o risk factors
Symptoms of acute Hepatitis
Unknown
Other:

CLINICAL DATA

Diagnosis Date: / /
Is patient symptomatic? Yes No Unk
If yes, onset date: / /
Was the patient
*Jaundiced?
*Hospitalized for Hepatitis?
Did the patient die from hepatitis?
Date of death: / /

DIAGNOSTIC TEST (Check all that apply)

Table with columns for test results (POS, NEG, UNK) and rows for various hepatitis tests including anti-HAV, anti-HBc, anti-HCV, and anti-HEV.

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

ALT [SGPT] Result Upper limit normal
AST [SGPT] Result Upper limit normal
Date of ALT result / /
Date of ALT result / /

*If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case? Yes No Unk

*Please send all perinatal surveillance forms (Mother Case Management Report and/or Infant Case Management Report) to the Perinatal Hepatitis B Prevention Program at: Phone: (512) 533-3158 Fax: (512) 533-3167

During the **2-6 weeks** prior to onset of symptoms:

Was the patient a contact of a person with confirmed or suspected Hepatitis A virus infection?..... Yes No Unk

If yes, was the contact (*check one*)

- Household member (non-sexual).....
- Sex partners.....
- Child cared for by this patient.....
- Babysitter of this patient.....
- Playmate.....
- Other.....

Was the patient:

- A child or employee in a daycare center, nursery, or preschool?.....
- A household contact of a child or employee in a day care center, nursery, or preschool?.....

If yes for either of these, was there an identified hepatitis A in the child care facility?.....

Please ask both of the following questions regardless of the patient's gender.

In the **2-6 weeks** before symptom onset how many:

- Male sex partners did the patient have?..... 0 1 2-5 UNK
- Female sex partners did the patient have?.....

In the **2-6 weeks** before symptom onset:

Did the patient inject drugs not prescribed by a doctor?.....

Did the patient use street drugs but not inject?.....

Did the patient **travel** outside of the U.S.A. or Canada?.....

- If yes, where? (Country) 1) _____ 2) _____

In the **3 months** prior to symptoms onset:

Did anyone in the patient's household travel outside of the U.S.A. or Canada?.....

- If yes, where? (Country) 1) _____ 2) _____

Is the patient suspected as being part of a common-source outbreak?.....

If yes, was the outbreak:

Foodborne -- associated with an infected food handler

Foodborne – NOT associated with an infected handler.....

- Specify food item _____

Waterborne.....

Source not identified.....

Was the patient employed as a food handler during the **TWO WEEKS** prior to onset of symptoms or while ill?.....

- If yes, where? _____
- Last day of work? ____/____/____

VACCINATION HISTORY

Has the patient ever received the hepatitis A vaccine?..... Yes No Unk

- If yes, how many doses?..... 1 >2
- In what year was the last dose received?.....

Has the patient ever received immune globulin?..... Yes No Unk

- If yes, when was the last dose received?..... ____/____/____
MO YR

Investigator's Name: _____ Agency name: _____

Phone: () _____ Date Investigation Initiated: ____/____/____ Date Completed: ____/____/____

Date Earliest Public Health Control Measure Initiated: ____/____/____

Comments:

During the **6 weeks-6 months** prior to onset of symptoms was the patient a contact of a confirmed or suspected acute or chronic hepatitis B case?

If yes, type of contact:

	Yes	No	Unk
• Sexual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Household (non-sexual).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please ask both of the following questions regardless of the patient's gender.

In the **6 months** before symptom onset how many:

	0	1	2-5	>5	Unk
• Male sex partners did the patient have?.....	<input type="checkbox"/>				
• Female sex partners did the patient have?.....	<input type="checkbox"/>				

Was the patient **EVER** treated for a sexually-transmitted disease?.....

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, in what year was the most recent treatment?

During the **6 weeks-6 months** prior to onset of symptoms:

- Inject drugs not prescribed by a doctor?.....
- Use street drugs but not inject?.....

During the **6 weeks-6 months** prior to onset of symptoms

Did the patient:

	Yes	No	Unk
• Undergo hemodialysis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have an accidental stick or puncture with a needle or other object contaminated with blood?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Receive blood or blood products [transfusion].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when?____/____/____			
• Receive any IV infusions and/or injections in the outpatient setting?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have other exposure to someone else's blood?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
specify: _____			

During the **6 weeks-6 months** prior to onset of symptoms

Was the patient employed in a medical or dental field involving direct contact with human blood?.....

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, frequency of direct blood contact:
Frequent (several times weekly) Infrequent

Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having contact with human blood?.....

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, frequency of direct blood contact:
Frequent (several times weekly) Infrequent

Did the patient receive a tattoo?.....

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Where was the tattooing performed? (**select all that apply**)

Commercial parlor/shop Correctional facility other _____

During the **6 weeks-6 months** prior to onset of symptoms

- Did the patient have any part of their body pierced (other than ear)?

Where was the piercing performed? (**select all that apply**)

Commercial parlor/shop Correctional facility other _____

	Yes	No	Unk
• Did the patient have dental work or oral surgery?....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did the patient have surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was the patient –(check all that apply)			
-hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-a resident of a long term care facility?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-incarcerated for longer than 24 hours?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type of facility (check all that apply)			
Prison.....	<input type="checkbox"/>	<input type="checkbox"/>	
Jail.....	<input type="checkbox"/>	<input type="checkbox"/>	
Juvenile facility.....	<input type="checkbox"/>	<input type="checkbox"/>	

During his/her lifetime, was the patient **EVER**

	Yes	No	Unk
• Incarcerated for longer than 6 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

-what year was the most recent incarceration?...

-for how long?..... _____ months.

Did the patient ever receive hepatitis B vaccine?

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, how many shots?.....

1	2	3+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In what year was the last shot received?.....

Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?.....

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, was the serum anti-HBs >10mIU/ml?.....

Yes	No	Unk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')

Non-sexual Household and Sexual Contacts Requiring Prophylaxis:

Name	Relation to Case	Age	HBIG	HB Vaccine
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

Control Measures (check all that apply):

<input type="checkbox"/> Notified blood center(s)	<input type="checkbox"/> Vaccinated susceptible contacts
<input type="checkbox"/> Notified dialysis center, surgeon(s), acupuncturist, and/or tattoo parlor	<input type="checkbox"/> Notified delivery hospital and obstetrician if a woman is pregnant
<input type="checkbox"/> Disinfected all equipment contaminated with blood or infectious body fluids	<input type="checkbox"/> Vaccinated infant born to HBsAg-positive women

Investigator's Name: _____ Agency name: _____

Phone: () _____ **Date Investigation Initiated:** ____/____/____ **Date Completed:** ____/____/____

Comments
