

**ADHS**

HEPATITIS A

Case Report Form

MEDSIS ID

If this form is being completed by a non-MEDSIS user, please complete the following information:

Person completing this form:

Phone:

Patient Name

Date of Birth

Gender

Race/Ethnicity

Address

Phone

Email

City

County

Zip

Died? ☐ Yes, date:☐ No☐ Unknown

CLINICAL & DIAGNOSTIC DATA

CLINICAL DATA

Is patient symptomatic?	<input type="checkbox"/> Yes	If yes, onset date:	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Did the patient have jaundice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Did the patient have diarrhea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Was the patient hospitalized for hepatitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

DIAGNOSTIC TESTS

Required for hep A: IgM antibody to hepatitis A (IgM anti-HAV)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Unknown	
Nucleic acid amplification test (e.g. PCR or genotyping)	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
If positive, specify results:				

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS

ALT Result:	Date of ALT result:	Total bilirubin:	Date of Tbili result:
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VACCINATION AND HEALTH HISTORY

Has the patient ever received a hepatitis A-containing vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
If yes, how many doses?	<input type="checkbox"/> One	<input type="checkbox"/> Two	<input type="checkbox"/> Unknown	Date received the last dose of hepatitis A vaccine:
Type of vaccine:	Manufacturer:		Lot #:	
Has the patient ever received immune globulin?	<input type="checkbox"/> Yes	Last dose received:	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Was the patient aware they had hepatitis prior to lab testing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Does the patient have a provider of care for hepatitis? This is any healthcare provider that monitors or treats the patient for viral hepatitis.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

Notes about clinical and diagnostic data

PATIENT HISTORY: CONTACTS, OCCUPATION, AND HOUSING

In the 2-6 weeks before symptom onset, was the patient a contact of a person with confirmed or suspected hepatitis A virus infection?

☐

Yes

☐

No

☐

Unknown

If yes, was the contact:

Household member (non-sexual)

☐

Yes

☐

No

☐

Unknown

Sexual partner

☐

Yes

☐

No

☐

Unknown

Child cared for by this patient

☐

Yes

☐

No

☐

Unknown

Babysitter or caregiver of this patient

☐

Yes

☐

No

☐

Unknown

Playmate

☐

Yes

☐

No

☐

Unknown

Other

☐

Yes, specify:

☐

No

☐

Unknown

CONTACTS

First and Last Name	DOB (or Age)	Gender	Phone	Onset date	Symptoms

OCCUPATION

In the 2-6 weeks before symptom onset, was the patient:

A child or employee in a day care center, nursery, or preschool?

☐

Yes

☐

No

☐

Unknown

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

☐

Yes

☐

No

☐

Unknown

If yes for either of these, was there an identified hepatitis A case in the childcare facility?

☐

Yes

☐

No

☐

Unknown

During the TWO WEEKS prior to onset of symptoms, or while ill, was the patient:

Employed as a food handler

☐

Yes

☐

No

☐

Unknown

Employed as a healthcare worker

☐

Yes

☐

No

☐

Unknown

HOUSING

In the 2-6 weeks before symptom onset, did the patient:

Experience homelessness? This includes living in a vehicle, couch surfing, staying in a shelter, sharing a hotel/motel room, or living in camps. **If yes**, indicate where patient spends days, spends nights, eats meals, and uses the restroom in notes below.

☐

Yes

☐

No

☐

Unknown

Visit, volunteer, work, or use services at an organization serving persons experiencing homelessness? This includes soup kitchen, homeless shelter, or medical clinic for homeless persons.

☐

Yes

☐

No

☐

Unknown

Stay at, seek services from, or work at a rehab, addiction treatment, or sober living facility?

☐

Yes

☐

No

☐

Unknown

Spend any time in jail, prison, or other correctional facility, including employees?

☐

Yes

☐

No

☐

Unknown

Description of place where patient stayed/worked/visited	City/State where patient stayed/worked/visited	Dates

Notes about contacts, occupation, and housing

PATIENT HISTORY: SEXUAL PARTNERS/DRUG USE

What is the patient's sexual preference?	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Homosexual	<input type="checkbox"/> Unknown
In the 2-6 weeks before symptom onset:				
Number of male sex partners the person had:				
Number of female sex partners the person had:				
Did the patient inject drugs not prescribed by a doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Did the patient use street drugs but not inject?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Is there evidence in the medical chart or elsewhere of drug use but method of drug use is unknown?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
If yes to drugs (any method), indicate types of drugs used				
<input type="checkbox"/> Benzodiazepines (benzos)	<input type="checkbox"/> Cannabis	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Heroin	<input type="checkbox"/> Methamphetamines
<input type="checkbox"/> Other opioids (if yes, indicate type in notes below)			<input type="checkbox"/> Other (if yes, indicate type in notes below)	
Was the patient prescribed any medications to treat opioid use disorder (e.g. medication-assisted treatment or MAT, such as suboxone or methadone)?	<input type="checkbox"/> Yes, specify:		<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Notes about sexual partners/drug use				

PATIENT HISTORY: TRAVEL

TRAVEL IN THE 2-6 WEEKS BEFORE SYMPTOM ONSET

In the 2-6 weeks before symptom onset, did the patient travel or live outside of the U.S.A. or Canada?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Destination (city, state country)	Date arrived	Date departed	Mode of transport	Lodging type, Address/Phone	Reason for travel*	
*Reasons for travel: Adoption, business, new immigrant, tourism, visiting relative and/or friend, other (specify), unknown						
In the 3 months before symptom onset, did anyone in the patient's household travel or live outside of the U.S.A. or Canada?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Country:		Country:		Country:		

PATIENT HISTORY: FOOD/WATER

Is the patient suspected of being part of a common-source outbreak? <i>Please also complete Outbreak Indicator in MEDSIS.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, was the outbreak:			
Foodborne -- associated with an infected food handler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Foodborne -- NOT associated with an infected food handler?	<input type="checkbox"/> Yes, specify food item:		<input type="checkbox"/> No <input type="checkbox"/> Unknown
Waterborne?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Source not identified	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Notes about contacts and occupation			

FOOD HISTORY**FOOD SOURCES AT HOME**

Please use this table to track food sources AT HOME in the 2-6 weeks before illness onset. This includes food that may have been obtained at grocery stores, warehouse stores, discount stores, ethnic food stores, farmers' markets, food delivered to home (e.g., Schwann's, Blue Apron), and donated food/food banks.

Food source at home (name of grocery store, market, etc.)	Address or cross streets, City, State	Story Loyalty Card, if applicable	Summary of foods generally purchased at this location

FOOD SOURCES AWAY FROM HOME

Please use this table to enter information about food sources consumed AWAY FROM HOME in the 2-6 weeks before illness onset. This includes restaurants, fast food restaurants, events where food was served, potlucks, weddings, meetings, catered meals, street vendors, concessions, convenience store/gas stations, etc.

Food source away from home (name of the restaurant, event, etc.)	Address or cross streets, City, State	Date ate at the restaurant/event/other	Foods eaten, including drinks, appetizers, and sides. Also include any notes about the food source.

During the 2-6 weeks before illness onset, did the patient eat any of the following foods?

Green onions, scallions, or chives ☐ Yes ☐ No ☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Herbs (e.g. basil, parsley, cilantro, etc.) ☐ Yes ☐ No ☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Leafy greens, including spinach, lettuce, etc. ☐ Yes ☐ No ☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Other vegetables ☐ Yes ☐ No ☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

MEDSIS ID:

Smoothie

☐ Yes☐ No☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Berries, fresh

☐ Yes☐ No☐ Unknown☐ Strawberries☐ Raspberries☐ Blueberries☐ Blackberries☐ Mixed berries☐ Other berries☐ Frozen berries of any type

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Pomegranate seeds or fruit

☐ Yes☐ No☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Other fruits

☐ Yes☐ No☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Fish or seafood

☐ Yes☐ No☐ Unknown☐ Fish eaten raw☐ Fish undercooked☐ Smoked or dried fish☐ Sushi☐ Oysters☐ Clams☐ Mussels☐ Scallops☐ Crab or lobster☐ Shrimp or prawns☐ Ceviche☐ Other fish, seafood, or seaweed products

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Deli meats

☐ Yes☐ No☐ Unknown

Details (type, variety, brand, how prepared, packaging, where purchased, dates purchased and consumed, etc.)

Notes about food history