**Utah Public Health**

**Name of Local Health Department**

**Address of Local Health Department**

*Phone:* ***(xxx) xxx-xxxx*** *Confidential Fax* ***(xxx) xxx-xxxx***

*Date:*

**Laboratory Testing:**

Test Result: Test Date:

Total anti-HAV Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

IgM anti-HAV Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HBsAg Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Total anti-HBc Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HBeAg Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HBV Genotype: ­ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

IgM anti-HBc Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Hep B NAT Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Anti-HCV Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HCV NAT Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HCV Genotype: ­ \_\_\_\_\_/\_\_\_\_\_/\_\_\_ \_\_

Anti-HDV Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

IgM anti-HEV Pos. Neg. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Diagnosis date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Is patient symptomatic? □ Yes □ No □ Unknown

□ Acute onset □ Anorexia □ Nausea □ Malaise □ Fever □ Vomiting □ Abdominal pain □ Headache □ Diarrhea

At diagnosis, was the patient:

* Jaundiced? □ Yes □ No □ Unknown
* Hospitalized for hepatitis? □ Yes □ No □ Unknown

Was patient pregnant? □ Yes □ No □ Unknown

* If yes, list the due date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Did patient die from hepatitis? □ Yes □ No □ Unknown

* Date of death: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Was patient aware he/she had viral hepatitis
prior to lab testing? □Yes □ No □ Unknown
Does patient have provider of care
for hepatitis? □Yes □ No □ Unknown Does patient have diabetes? □ Yes □ No □ Unknown

* Diabetes diagnosis date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

Race: *(check all that apply)*

*□* White *□* Black/African American *□* Other Race, specify\_\_\_\_\_\_\_\_\_\_\_\_

*□* Asian *□* American Indian/Alaskan Native *□* Native Hawaiian or Pacific Islander

Ethnicity: *□* Hispanic

 *□* Not Hispanic *□* Other/Unknown

Sex: *(circle one)* Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ (years)

M F U Place of birth: *□* U.S. *□* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLINICAL INFORMATION**

Why was patient tested? (*check all that apply*):

 □ Symptoms of acute hepatitis □ Screening asymptomatic patient with no risk factors

 □ Screening asymptomatic patient with reported risk factors □ Prenatal screening

 □ Evaluation of elevated liver enzymes □ Blood/organ donor screening

 □ Follow-up testing for previous marker of viral hepatitis □ Unknown

 □ Year of birth (1945-1965) □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Onset Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Clinician Name: Clinician Phone #:

**CONTACT INFORMATION**

Prefix: (Mr./Mrs./Miss/Ms./etc.) Last Name: First Name: MI:

Preferred Name (Nickname): Maiden:

Address: City: State:

County: Zip: Date of Public Health Report:

Phone #1 (H/W/C): Phone #2 (H/W/C): Case ID:

**HEPATITIS B (ACUTE & CHRONIC) CONFIDENTIAL CASE REPORT**

Were chemistries done? □ Yes □ No □ Unknown

Name of laboratory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 ALT (SGPT) results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Upper limit normal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 AST (SGOT) results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Upper limit normal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bilirubin results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Upper limit normal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis (*check all that apply*):

□ Acute hepatitis A □ Acute hepatitis C □ Chronic HBV infection □ Perinatal HBV infection

□ Acute hepatitis B □ Acute hepatitis E □ Chronic HCV infection □ Perinatal HCV infection

During the **6 weeks-6 months** prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 □ Yes □ No □ Unknown

* If yes, type of contact:
* Sexual □ Yes □ No □ Unknown
* Household (non-sexual) □ Yes □ No □ Unknown
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During the **6 weeks-6 months** prior to onset of symptoms **did the patient:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

* Undergo hemodialysis? □ Yes □ No □ Unknown
* Have an accidental stick with a needle/object contaminated with/ blood? □ Yes □ No □ Unknown
* Receive blood or blood products (transfusion)? □ Yes □ No □ Unknown
	+ If yes, when? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
* Receive any IV infusions and/or injections in the outpatient setting? □ Yes □ No □ Unknown
* Have other exposure to another person’s blood? □ Yes □ No □ Unknown
	+ Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* Was the patient employed in a medical or dental field involving

direct contact with human blood? □ Yes □ No □ Unknown

* If yes, frequency of blood contact?

□ Frequent (several times weekly) □ Infrequent

* Was the patient employed as a public safety worker (fire fighter, law

enforcement, or correctional officer) having direct contact with blood? □ Yes □ No □ Unknown

* If yes, frequency of blood contact?

□ Frequent (several times weekly) □ Infrequent

* Did the patient receive a tattoo? □ Yes □ No □ Unknown
	+ Where was the tattooing performed? (check *all that apply*)

□ Commercial parlor/shop □ Correctional facility □ Other

**Ask both of the following questions regardless of the patient’s gender.**

In the **6 months** before symptom onset, how many: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

* + Male sex partners did the patient have?
	+ Female sex partners did the patient have?

Was the patient **EVER** treated for a sexually transmitted disease? □ Yes □ No □ Unknown

* If yes, in what year was the most recent treatment? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**PATIENT HISTORY (ACUTE CASES ONLY)**

During the **6 weeks- 6 months** prior to onset of symptoms did the patient: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

* Inject drugs not prescribed by a doctor? □ Yes □ No □ Unknown
* Use street drugs, but not inject? □ Yes □ No □ Unknown
* Did the patient have any part of his/her body pierced (other than ear)? □ Yes □ No □ Unknown
	+ Where was the piercing performed? (*check all that apply*)

 □ Commercial parlor/shop □ Correctional facility □ Other\_\_\_\_\_\_\_\_

* Did the patient have dental work or oral surgery? □ Yes □ No □ Unknown
* Did the patient have surgery? (other than oral surgery) □ Yes □ No □ Unknown
* Was the patient: (*check all that apply*)
	+ Hospitalized? □ Yes □ No □ Unknown
	+ A resident of a long-term care facility? □ Yes □ No □ Unknown
	+ Incarcerated for longer than 24 hours? □ Yes □ No □ Unknown
		- If yes, what type of facility (*check all that apply*)

□ Prison □ Jail □ Juvenile facility

During his/her lifetime, was the patient **EVER** incarcerated for longer

than 6 months? □ Yes □ No □ Unknown

* If yes,
	+ - What year was his/her most recent incarceration? \_\_\_\_\_\_\_\_\_
		- For how long? \_\_\_\_\_\_\_\_\_ (months)

Did patient have a negative HBsAg test within 6 months prior to a positive test? □ Yes □ No □ Unknown

* If yes, verified test date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Was the patient tested for hepatitis D? □ Yes □ No □ Unknown

Did patient have co-infection with hepatitis D? □ Yes □ No □ Unknown

Did the patient receive clotting factor concentrates produced prior to 1987? □ Yes □ No □ Unknown

Was the patient ever on long-term hemodialysis? □ Yes □ No □ Unknown

Has the patient ever injected drugs not prescribed by a doctor,

even if only once or a few times? □ Yes □ No □ Unknown

How many sex partners has the patient had (approximate lifetime)? \_\_\_\_\_\_\_\_\_

Was the patient ever incarcerated? □ Yes □ No □ Unknown

Was the patient ever treated for a sexually transmitted disease? □ Yes □ No □ Unknown

Was the patient ever a contact of a person who had hepatitis? □ Yes □ No □ Unknown

* + If yes, type of contact:
* Sexual □ Yes □ No □ Unknown
* Household (non-sexual) □ Yes □ No □ Unknown
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No □ Unknown

Was the patient ever employed in a medical or dental field involving

direct contact with human blood? □ Yes □ No □ Unknown

What is the birth country of the mother? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient received medication for the type of hepatitis being reported? □ Yes □ No □ Unknown

**PATIENT HISTORY (CHRONIC CASES ONLY)**

**VACCINE HISTORY**

**Did the patient ever receive a hepatitis B vaccine?** □ Yes □ No □ Unknown

* **If yes, how many doses?** □ 1 □ 2 □ 3+

Date of last dose received? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2
months after the last dose?** □ Yes □ No □ Unknown

* If yes, was the serum ani-HBs ≥ 10mIU/ml? (answer ‘yes’ if

 laboratory results were reported as ‘positive’ or ‘reactive’) □ Yes □ No □ Unknown

Has patient ever received a hepatitis A-containing vaccine? □ Yes □ No □ Unknown

**CASE CONTACTS**

**REPORTING INFORMATION**

Reported by: *(check all that apply)*

□ Hospital/ICP □ Clinic/doctor’s office □ Lab □ General public □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Date the lab reported to the clinician \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Reporter’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reporter’s agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date reported to public health: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

LHD Investigator: Phone: Date submitted to UDOH: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

LHD Reviewer:

LHD Case classification: *(check one)*

*□* Confirmed □ Probable □ Suspect □ Unknown □ Resolved □ Pending □ Out of state □ Not a case

List any high-risk contacts during the 6 months prior to onset of symptoms or seroconversion:

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_\_\_

Preferred Name (Nickname):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_

Phone #1 (H/W/C): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #2 (H/W/C):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address or other contact information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_\_\_

Preferred Name (Nickname):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_

Phone #1 (H/W/C): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #2 (H/W/C):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address or other contact information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_\_\_

Preferred Name (Nickname):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_

Phone #1 (H/W/C): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #2 (H/W/C):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address or other contact information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Contact: □ Sexual □ Household (non-sexual) □ Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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