

Patient Name: _____ Date of Birth: ____/____/____ Serial Number: _____

**New York State Department of Health
Hepatitis A Supplemental**

General Instructions: All suspected hepatitis A cases should be followed-up, beginning with clinical information obtained from the provider. Please note that this form serves multiple purposes: the questions are designed to determine whether or not the patient is truly a case of hepatitis A infection, the patient's source of infection and appropriate control measures. Once a diagnosis can be confirmed, patients must be interviewed to complete the remainder of the form. Please attempt to complete this form in its entirety, and accurately to maintain data quality. **Please do not respond "unknown"** to any questions unless the patient reports that they do not know the answer to the question. If the case meets CSTE case definition, the information gathered from providers and patients should be reported electronically via CDESS.

PATIENT INFORMATION

Alternate Name: _____ Reason for alternate name: Alias
 Foreign Born/Americanized Name
 Other, specify: _____
 Unknown

Inmate Instructions: The following applies to NYS Department of Corrections (DOCS) Inmates only (do not enter information for federal, out of state or county jail inmates). Please enter the DOCS Department Identification Number (DIN) that was assigned to the patient at the time of the FIRST positive hepatitis test result. Inmates may have multiple DINs over their lifetime; however, please do not change the DIN originally reported. "County of Commitment" is the county in which the inmate was convicted. NYSDOCS inmate information can be located online at: <http://nysdocslookup.docs.state.ny.us/>.

DIN: _____ (XX-X-XXXX) County of Commitment: _____

CLINICAL INFORMATION

	Yes	No	Unk
Did the patient have a discrete onset of symptoms at time of diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, symptom onset date: ___/___/___</i>			
<i>If yes, symptoms:</i>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clay-colored bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was patient jaundiced at time of diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, jaundice onset date: ___/___/___</i>			

Reason for Testing (Select all that apply):

- Symptoms of acute hepatitis
- Screening of a patient with no symptoms, with reported risk factors
- Screening of a patient with no symptoms, with no reported risk factors (e.g., patient request)
- Evaluation of elevated liver enzymes
- Occupational health screening
- Contact of a confirmed case
- Refugee/immigration screening
- International adoptee screening
- Post-exposure screening
- Pre-vaccination screening
- Post-vaccination screening
- Other, specify: _____

	Yes	No	Unk
If patient was hospitalized at the time of diagnosis, was the patient hospitalized specifically for hepatitis A?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did patient die due to complications from hepatitis A (i.e., primary cause of death)? If yes, date of death: ___/___/___ ICD code (State DOH only) : _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If this case has a diagnosis of hepatitis A and has not had laboratory testing, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EPIDEMIOLOGIC RISK FACTORS

Risk Factor Instructions: Please ask all risk factor questions based on the patient's incubation period, 2-6 weeks prior to the onset of symptoms. Risk factors listed on this form are by no means exhaustive. Please gather as much detail about risk factors as possible. Details can be recorded in the comments section if there is not already a space on the form for the information. This section is important in the identification of outbreaks and missed opportunities for prevention.

Patient country of birth*: _____ Exposure window: ___/___/___ to ___/___/___

Note: Exposure window/incubation period calculators can be found online at <http://www.nyhealth.gov/diseases/communicable/hepatitis/surveillance.htm>. The exposure window or incubation period for hepatitis A virus infection is 2-6 weeks prior to the onset of symptoms.

CLOSE CONTACTS

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

	Yes	No	Unk
Was the patient a contact of a person with a confirmed or suspected hepatitis A virus infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, type of contact (indicate all that apply):

	Yes	No	Unk
Household member (non-sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child cared for by this patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babysitter of this patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playmate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-household relative/friend (non-sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV drug use partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-IV drug use partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumed food handled by a foodworker with hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the patient a child or employee in a childcare center, nursery, or preschool? Yes No Unk

Was the patient a household contact of a child or employee in a childcare center, nursery, or preschool? Yes No Unk

If yes to either of these, was there an identified hepatitis A case in the childcare facility? Yes No Unk

In the **3 MONTHS** prior to onset of symptoms, did anyone in the patient's household (other than the case patient) live or travel outside the continental U.S. or Canada? Yes No Unk

If yes, country*: _____ From Date: ___/___/___ To Date: ___/___/___

FOOD /WATER EXPOSURE

In the 2-6 weeks prior to onset of symptoms, did the patient eat any of the following **raw or undercooked** shellfish?

Yes No Unk

Shellfish Type	Location Type	Location Name	Date Eaten
<input type="checkbox"/> Clams <input type="checkbox"/> Oysters <input type="checkbox"/> Mussels <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Grocery store-seafood counter <input type="checkbox"/> Grocery store-other <input type="checkbox"/> Restaurant <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		____/____/____

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

Yes No Unk

If yes, select outbreak type:

- Foodborne, associated with infected foodworker
- Foodborne, not associated with infected foodworker, specify: _____
- Waterborne
- Associated with a refugee camp
- Source not specified
- Other, specify: _____

TRAVEL HISTORY

Note: If the patient visited or lived in more than one country during the 2-6 weeks prior to onset of symptoms, additional locations may be noted in the comments section.

Did the patient travel or live outside of the U.S. or Canada:

Yes No Unk

If yes, please provide details:

Country*: _____ Departure Date: ____/____/____ Return Date: ____/____/____

Reason for travel:

- Tourism
- Business
- Visiting friends or relatives
- Recent immigrant
- International adoption
- Military
- Other, specify: _____

Did the patient stay at a resort?

Yes No Unk

If yes, specify resort name: _____

Did the patient travel on a cruise?

If yes, specify cruise ship name: _____

LIFESTYLE RISK FACTORS

Note: Please ask the following 2 questions regardless of patient's gender.

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

Male sex partners did the patient have: 0 1 2-5 >5 Unknown
 Female sex partners did the patient have: 0 1 2-5 >5 Unknown

What is the patient's sexual preference?

Heterosexual Homosexual Bisexual Refused

	Yes	No	Unk
Did patient have sexual contact with a person born outside of the US or Canada? If yes, where was the person born (country*): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient inject drugs not prescribed by a doctor? If yes, type(s) of drug(s): Street Drugs Steroids Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the patient share drugs with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the patient share equipment/paraphernalia with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the patient share needles with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient ever use street drugs but not inject? If yes, method(s) of drug use: Smoked Snorted Ingested orally Inhaled Anal insertion Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snorted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ingested orally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhaled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the patient share drugs with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the patient share equipment/paraphernalia with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the **2 WEEKS** prior to onset of symptoms, or while ill, did the index case work or volunteer in any of the following settings:

	Yes	No	Unk	Date(s) Worked:
Food service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___ ___/___/___
Childcare facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___ ___/___/___
Healthcare facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___ ___/___/___

Laboratory Data:

Note: The laboratory test results listed in bold type below are those which are required in order to determine case status. *The most efficient means of populating the CDESS forms with laboratory data is to transfer the information from ECLRS electronically versus manually adding a new case report and results. Additional instructions for completing the laboratory testing grid on CDESS can be found in the 2011 Viral Hepatitis Surveillance Guidelines.*

Test Type	Test Date	Positive	Negative	Other Numeric Result
Total anti-HAV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
IgM anti-HAV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HBsAg	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-HBs	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
Total anti-HBc	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
IgM anti-HBc	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HBeAg	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HBeAb	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HBV NAT	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HBV Genotype	___/___/___			
Anti-HCV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Positive signal-to-cutoff ratio <input type="checkbox"/> Negative signal-to-cutoff ratio <input type="checkbox"/> Signal-to-cutoff ratio not reported
Anti-HCV by RIBA	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HCV NAT	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HCV Genotype	___/___/___			
Total anti-HDV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
IgM anti-HDV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HDAg	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
HDV NAT	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
Total anti-HEV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
IgM anti-HEV	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
ALT { SGPT }	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	
AST {SGOT }	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	

Note: The laboratory tests listed in bold type below are those which are required in order to determine case status.

VACCINE HISTORY:

Yes No Unk

Did patient ever receive hepatitis A immunoglobulin?

If yes, date of last dose: ___/___/___

Did patient ever receive hepatitis A vaccine?

If yes, how many doses: 1 2+

If yes, date of last dose: ___/___/___

CONTROL MEASURES:

(Prevention of secondary infections and transmission to others)

Total number of at-risk close contacts eligible for IG: _____

Number of at-risk close contacts who received IG: _____

Total number of at-risk close contacts eligible for hepatitis A vaccine: _____

Number of at-risk close contacts who received hepatitis A vaccine: _____

Please note: The CDC recommends that close contacts of persons diagnosed with hepatitis A virus be given immunoglobulin and/or hepatitis A vaccine. For more information, please visit <http://cdc.gov/hepatitis/HAV/HAVfaq.htm#vaccine>.

Counseling Information

Yes No Unk

Provided by Physician Date: ___/___/___

Provided by LHD Date: ___/___/___

Provided by NYSDOH Date: ___/___/___

Local Health Department Follow-up

Investigation Start Date: __/__/__

Method of initial healthcare provider follow-up:

- Dear Doctor Letter Sent Date: __/__/__ Received Date: __/__/__
- Telephone call to provider
- Medical Record Review
- Electronic Medical Record Review
- Other
- None

Was healthcare provider interviewed? Interview Date: __/__/__

Yes **No** **Unk**

Did healthcare provider confirm HAV infection?

- Yes
- No
- No Response
- Not Attempted

Yes **No** **Unk**

Was the patient interviewed? Interview date: __/__/__

Method of patient-follow-up:

- Telephone call to patient
- Chart Review
- Other, specify: _____
- None

Comments:

Investigated by: _____ Date Investigation completed: __/__/__

**A list of countries can be found in the 2011 Viral Hepatitis Surveillance Guidelines.*