

Hepatitis A

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____

Referred to another state: _____

CASE

Last name: _____
First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Maiden name: _____ Suffix: _____

Gender: Female Male Other _____

Address line: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Zip: _____ City: _____

Marital status: Single Married Separated
 Divorced Parent with partner Widowed

State: _____ County: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

Phone: (____) - ____ - ____ Type: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Long-term care resident: Yes No Unknown

Parent/Guardian name: _____

Facility name: _____

Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____

Last name: _____

Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown

First name: _____

Date of Death ____ / ____ / ____

Event exception: Case could not be found
 Case could not be interviewed
 Case refused interview
 Other – see notes

Provider title: ARNP MD DO NP PA

Outbreak related: Yes No Unknown

Outbreak name: _____

Facility name: _____

Exposure setting: _____

Address line 1: _____

Epi-linked: Yes No Unk To whom: _____

Address line 2: _____

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

Zip code: _____ City: _____

State: _____ Country: _____

State: _____ County: _____

Phone: (____) - ____ - ____ Type: _____

Healthcare provider information

LABORATORY FINDINGS

Laboratory: _____

Accession #: _____

Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____

Specimen source: Blood/serum Other

Result date: ____ / ____ / ____

Result type: Preliminary Final

Test type: IgM HAV

Result: Positive Negative

Organism: **Hepatitis A virus**

IgG HAV Total IgM/IgG HAV

Borderline Equivocal Not done

Laboratory: _____

Accession #: _____

Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____

Specimen source: Blood/serum Other

Result date: ____ / ____ / ____

Result type: Preliminary Final

Test type: IgM HAV IgG HAV

Result: Positive Negative

Organism: _____

Total IgM/IgG HAV

Borderline Equivocal Not done

Laboratory: _____	Accession #: _____	Collection date: ____/____/____
Date received: ____/____/____	Specimen source: _____	Result date: ____/____/____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Test type: <input type="checkbox"/> IgM HAV <input type="checkbox"/> IgG HAV <input type="checkbox"/> Total IgM/IgG HAV	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline <input type="checkbox"/> Equivocal <input type="checkbox"/> Not done
Hepatitis A virus		
Organism: _____		

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____/____/____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: <input type="checkbox"/> Laboratorian <input type="checkbox"/> Nursing <input type="checkbox"/> Nurse practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Physician assistant <input type="checkbox"/> Other
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____/____/____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____	Date resolved: ____/____/____
Dark urine: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____	Date resolved: ____/____/____
Diarrhea: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____	Date resolved: ____/____/____
Other symptoms: <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Fever <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia <input type="checkbox"/> Malaise		
Testing reason: <input type="checkbox"/> Elevated liver enzymes <input type="checkbox"/> Symptoms of disease other than elevated liver enzymes <input type="checkbox"/> Exposure to risk factor associated with hepatitis A <input type="checkbox"/> Testing for immunity to hepatitis A <input type="checkbox"/> Exposure to someone with confirmed hepatitis A <input type="checkbox"/> Screening for blood/plasma donation		

ALT performed? Yes No Unk

Result (in IU/l): _____

Expected min (in IU/l): _____

Expected max in IU/l): _____

AST performed? Yes No Unk

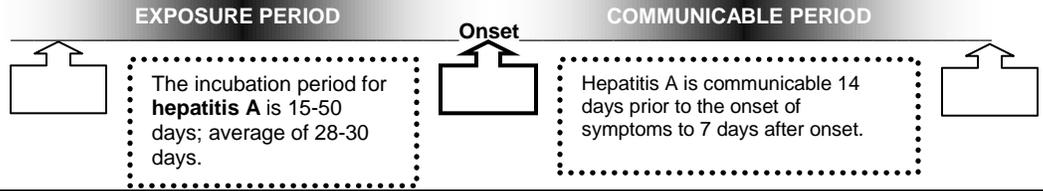
Result (in IU/l): _____

Expected min (in IU/l): _____

Expected max in IU/l): _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

In the last 30 days have you known someone with jaundice (yellow skin or eyes) Yes No Unknown

If yes Name _____ Relationship _____

In the last 30 days have you known someone that has been diagnosed with hepatitis A Yes No Unknown

If yes Name _____ Relationship _____

Vaccinated for hepatitis A? Yes No Unknown

Date vaccinated: ____ / ____ / ____

Date vaccinated: ____ / ____ / ____

Lot #: _____

Lot #: _____

Vaccine type: _____

Vaccine type: _____

Manufacturer: _____

Manufacturer: _____

Number of vaccinations: _____

In the 50 days prior to the onset of the symptoms did the case:

Travel within Iowa? Yes No Unk City in Iowa: _____

Departure date: ____ / ____ / ____

Return date: ____ / ____ / ____

Travel within U.S.? Yes No Unk State: _____ City: _____

Departure date: ____ / ____ / ____

Return date: ____ / ____ / ____

Travel outside U.S.? Yes No Unk Country: _____

Departure date: ____ / ____ / ____

Return date: ____ / ____ / ____

Visit restaurants? Yes No Unknown

If Yes, complete the table below:

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Attend Group Gatherings? Yes No Unknown

If Yes, complete the following table:

Location of gathering	Address/Zip	Date visited	Foods consumed	Others ill?
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____ / ____ / ____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Dietary Information – In the 50 days prior to onset of symptoms did the case consume:

Raw shellfish: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____ / ____ / ____	To dates consumed: ____ / ____ / ____
List all source/types: _____	List all brand names: _____	
Unpasteurized Mexican-style cheese: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____ / ____ / ____	To dates consumed: ____ / ____ / ____
List all source/types: _____	List all brand names: _____	
Other unpasteurized products: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____ / ____ / ____	To dates consumed: ____ / ____ / ____
List all source/types: _____	List all brand names: _____	
Raw fruits: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____ / ____ / ____	To dates consumed: ____ / ____ / ____

List all source/types: _____	List all brand names: _____
Raw vegetables: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____ / ____ / ____ To dates consumed: ____ / ____ / ____
List all source/types: _____	List all brand names: _____

Other Exposures – In the 50 days prior to the onset of symptoms did the case:

Wear diapers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Have contact with diapers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Do street drugs or inject steroids: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Have sex with someone with similar symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Sexual preference: <input type="checkbox"/> Hetero <input type="checkbox"/> Bisexual <input type="checkbox"/> Homo <input type="checkbox"/> Unknown

CONTACTS

Number of people living in case's household: _____ Close contacts with the case and/or same exposures? Yes No Unk

Close contacts of case or close contacts with same exposures

Name	DOB	Gender	Address/Phone
_____ / ____ / ____		<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - -
Relationship to case			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Roommate		<input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Sexual contact <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Significant other	
<input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Work/school/child care <input type="checkbox"/> Healthcare provider <input type="checkbox"/> Unknown/Other			
Documented history of hepatitis A disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Immune globulin	Contact wt: _____	Date vaccinated: ____ / ____ / ____
Received IG within 14 days of exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Date given: ____ / ____ / ____	Vaccine manufacturer: _____
Previously vaccinated for hepatitis A? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Dose: _____ Unit: _____	Vaccine type: _____
Vaccinated for hepatitis A w/in 14 days of exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Route: _____	Number of vaccinations: _____
		Hep A vaccine	

Name	DOB	Gender	Address/Phone
_____ / ____ / ____		<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - -
Relationship to case			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Roommate		<input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Sexual contact <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Significant other	
<input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Work/school/child care <input type="checkbox"/> Healthcare provider <input type="checkbox"/> Unknown/Other			
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Previously vaccinated for hepatitis A? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Dose: _____ Unit: _____	Vaccine type: _____
Vaccinated for hepatitis A w/in 14 days of exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Route: _____	Number of vaccinations: _____
		Hep A vaccine	

Name	DOB	Gender	Address/Phone
_____ / ____ / ____		<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - -
Relationship to case			
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Roommate		<input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Sexual contact <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Significant other	
<input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Work/school/child care <input type="checkbox"/> Healthcare provider <input type="checkbox"/> Unknown/Other			
Documented history of hepatitis A disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Contact wt: _____	Date vaccinated: ____ / ____ / ____

