VPD-5/6
Revised July 2017

Viral Hepatitis Investigation Form

Complete in addition to the Notification of Infectious Disease Form (EPI-1). In the event of an outbreak additional forms and specimen collection are required for testing, a VIDOH-EPID staff will coordinate additional paperwork and investigation.

Form contains:
Page 1 ..... General Information
Page 2 ..... Hep A **VPD-5
Page 3 ..... Hep B **VPD-6
Page 4 ..... Hep C
Page 5 ..... Hep E

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

- ☐ **Confirmed Acute hepatitis A** ☐**Chronic**_____
- ☐ **Confirmed Acute hepatitis B** ☐**NAC**_____
- ☐ **Confirmed Acute hepatitis C** ☐**Suspect hepatitis C**
- ☐ **Confirmed Acute hepatitis E** ☐**Probable hepatitis E**

Patient's Name: _____ (last) (first)
Address: _____
City: _____ (E)State: _____ Zip: _____
Region: _____ Phone: ( ) _____
Parent/Guardian: _____
Physician: _____ Phone: ( ) _____
Address: _____
_____

Reported By: _____
Agency: _____
Phone: ( ) _____
Date: _____/_____/_____

Report Given to: _____
Organization: _____
Phone: ( ) _____

DEMOGRAPHICS: *DATE OF BIRTH:* _____/_____/_____ *AGE:* _____ *PLACE OF BIRTH*: ☐ USVI ☐USA ☐ Other:_____ ☐ Unknown

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

If yes, estimated date and location of delivery: ____/____/____

Obstetrician's name, address, and phone #: _____

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: _ __/__ _/_ __

	Yes	No	Unk
Is patient symptomatic?.....	☐	☐	☐
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*)

	POS	NEG	UNK
Total antibody to hepatitis A virus [total anti-HAV].....	☐	☐	☐
IgM antibody to hepatitis A virus [IgM anti-HAV].....	☐	☐	☐
Hepatitis B surface antigen [HBsAg].....	☐	☐	☐
Total antibody to hepatitis B core antigen [total anti-HBc]...	☐	☐	☐
IgM antibody to hepatitis B core antigen [IgM anti-HBc].....	☐	☐	☐
Antibody to hepatitis C virus [anti-HCV].....	☐	☐	☐
Anti-HCV signal to cut-off ratio_____			
Supplemental anti-HCV assay [e.g. RIBA].....	☐	☐	☐
HCV RNA [e.g., PCR].....	☐	☐	☐
IgM antibody to hepatitis E virus [anti-HEV] (Lab_____)	☐	☐	☐
HEV RNA PCR?.....	☐	☐	☐

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 and epidemiologic link between this patient and a laboratory-confirmed hepatitis A case?..... Yes ☐ No ☐ Unk ☐

***Please fax a copy of all perinatal reports using the Notification of Infectious Disease Form (EPI-1) to the Perinatal Hepatitis B Prevention Program at (340) 777-8762.**

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

	Yes	No	Unk
Was the patient a contact of a person with confirmed or suspected Hepatitis A virus infection?	☐	☐	☐
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:	0	1	2-5	UNK
• Male sex partners did the patient have?	☐	☐	☐	☐
• Female sex partners did the patient have?	☐	☐	☐	☐

In the **2-6 weeks** before symptom onset:	Yes	No	Unk
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:

	Yes	No	Unk
Did anyone in the patient's household travel outside of the U.S.A. or Canada?	☐	☐	☐

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

	Yes	No	Unk
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

	Yes	No	Unk
Has the patient ever received the hepatitis A vaccine?	☐	☐	☐
• If yes, how many doses?	1 ☐	>2 ☐	
• In what year was the last dose received?	☐☐☐☐		
Has the patient ever received immune globulin?	☐	☐	☐
• 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: _____/_____/_____ ***This is a CDC required question.***

Comments:

Patient name:_____ **Patient History – Acute Hepatitis B** NBS Patient ID#:_____

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……	☐	☐	☐
• Household (non-sexual)……..	☐	☐	☐
• Other……..	☐	☐	☐

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?.....	☐	☐	☐	☐	☐
• Female sex partners did the patient have?.....	☐	☐	☐	☐	☐

	Yes	No	Unk
Was the patient ***EVER*** treated for a sexually-transmitted disease?.....	☐	☐	☐

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

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

	Yes	No	Unk
• 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?.....	☐	☐	☐
• Have an accidental stick or puncture with a needle or other object contaminated with blood?.....	☐	☐	☐
• Receive blood or blood products [transfusion]…. If yes, when?_____/_____/_____	☐	☐	☐
• Receive any IV infusions and/or injections in the outpatient setting?.....	☐	☐	☐
• Have other exposure to someone else's blood?.. specify: _____	☐	☐	☐

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

	Yes	No	Unk
Was the patient employed in a medical or dental field Involving direct contact with human blood?.....	☐	☐	☐

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

	Yes	No	Unk
Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having contact with human blood?.....	☐	☐	☐

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

	Yes	No	Unk
Did the patient receive a tattoo?.....	☐	☐	☐

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?....	☐	☐	☐
• Did the patient have surgery?.....	☐	☐	☐
• Was the patient –*(check all that apply)*			
-hospitalized?.....	☐	☐	☐
-a resident of a long term care facility?.....	☐	☐	☐
-incarcerated for longer than 24 hours?.....	☐	☐	☐
If yes, what type of facility *(check all that apply)*			
Prison……	☐	☐	
Jail……..	☐	☐	
Juvenile facility……..	☐	☐	

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

	Yes	No	Unk
• Incarcerated for longer than 6 months?.....	☐	☐	☐

If yes,
-what year was the most recent incarceration?... ☐☐☐☐
-for how long?…… ___ ___ months.

	Yes	No	Unk
Did the patient ever receive hepatitis B vaccine?	☐	☐	☐
	1	2	3+
If yes, how many shots?.....	☐	☐	☐

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

	Yes	No	Unk
Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose?.....	☐	☐	☐
If yes, was the serum anti-HBs >10mIU/ml?..... (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):***

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

Investigator's Name: _____ Agency name: _____

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

Comments:

Patient name:_____ **Patient History – Acute Hepatitis C** NBS Patient ID#:_____

During the **2 weeks-6 months** prior to onset of symptoms was the patient a contact of a confirmed or suspected acute or chronic hepatitis C case?

If yes, type of contact:

	Yes	No	Unk
• Sexual……	☐	☐	☐
• Household (non-sexual)……	☐	☐	☐
• Other……	☐	☐	☐

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?.....	☐	☐	☐	☐	☐
• Female sex partners did the patient have?.....	☐	☐	☐	☐	☐

	Yes	No	Unk
Was the patient ***EVER*** treated for a sexually-transmitted disease?.....	☐	☐	☐

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

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

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

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

Did the patient:

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

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

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

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?.....	☐	☐	☐

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

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

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

☐ Commercial parlor/shop ☐ Correctional facility ☐ other_____

During the **2 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?...	☐	☐	☐
• Did the patient have surgery?.....	☐	☐	☐
• Was the patient –*(check all that apply)*			
-hospitalized?.....	☐	☐	☐
-a resident of a long term care facility?.....	☐	☐	☐
-incarcerated for longer than 24 hours?.....	☐	☐	☐
If yes, what type of facility *(check all that apply)*			
Prison……..	☐	☐	
Jail……..	☐	☐	
Juvenile facility……..	☐	☐	

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

	Yes	No	Unk
• Incarcerated for longer than 6 months?.....	☐	☐	☐

If yes,
-what year was the most recent incarceration?. ☐☐☐☐

-for how long?…….. ___ ___ months.

Control Measures ***(check all that apply):***
☐ Notified blood center(s)
☐ Notified delivery hospital and obstetrician if women is pregnant
☐ Notified dialysis center, surgeon(s), acupuncturist, and/or tattoo parlor
☐ Disinfected all equipment contaminated with blood or infectious body fluids

Investigator's Name: _____ Agency name: _____

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

Comments:

Patient name:_____ **Patient History – Acute Hepatitis E** NBS Patient ID#:_____

During the 2-9 weeks prior to onset of symptoms:

What was the source of the patient's *drinking* water? ***(select all that apply)***
☐ 1. Municipal (city or town water system) ☐ 2. Well ☐ 3. Bottled /Brand:_____ ☐ 4. River ☐ 5. Other:_____
How was the drinking water treated?
Water No.1:
☐ Boiled ☐ Filtered ☐ Chlorinated ☐ Not treated ☐ Not treated at home (e.g. bottled or municipal water) ☐ Other:_____
Water No.2:
☐ Boiled ☐ Filtered ☐ Chlorinated ☐ Not treated ☐ Not treated at home (e.g. bottled or municipal water) ☐ Other:_____
How was patient's water treated, for hand washing, bathing, brushing teeth, and dish washing?
☐ Boiled ☐ Filtered ☐ Chlorinated ☐ Not treated ☐ Not treated at home (e.g. bottled or municipal water) ☐ Other:_____

	Yes	No	Unk
Was the patient a contact of a person with confirmed or suspected Hepatitis E virus infection?	☐	☐	☐
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 E in the child care facility?	☐	☐	☐

Did the patient have contact (includes hunting wild game) **with any animals**? ☐ Yes ☐ No ☐ Unknown
If yes, what kind? Cattle Horses Camels Sheep Goats Pigs Dogs Cats Monkeys Chickens Other:_____

Did the patient consume shellfish, uncooked/undercooked pork or deer meat? ☐ Yes ☐No ☐Unknown

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

In the 2-9 weeks before symptom onset how many:	0	1	2-5	UNK
• Male sex partners did the patient have?	☐	☐	☐	☐
• Female sex partners did the patient have?	☐	☐	☐	☐

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.?	☐	☐	☐
• 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 <u>TWO WEEKS</u> prior to onset of symptoms or while ill?	☐	☐	☐
• If yes, where? _____			
• Last day of work? _____/____/____			

Investigator's Name: _____ Agency name: _____

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

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

Comments: