

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

**HEPATITIS A
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 14**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

LABORATORY TESTING: Specify "IgM" and/or "IgG" and/or "total antibody" as appropriate Give details below.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

**NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE**

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY:

Fever Y N U
 Yes, subjective No
 Yes, measured Unknown

Fatigue/malaise/weakness Y N U

Loss of appetite (anorexia) Y N U

Weight loss with illness Y N U

Muscle aches/pains (myalgias) Y N U

Nausea Y N U

Vomiting Y N U

Abdominal pain or cramps Y N U

Diarrhea Y N U

Enlarged liver (hepatomegaly) Y N U

Elevated liver enzymes Y N U

Jaundice (yellow skin, eyes, light or gray stools, hyperbilirubinemia) Y N U

If yes:

Date of onset: (mm/dd/yyyy) _____

Dark urine (bilirubinuria) Y N U

If yes:

Date of onset: (mm/dd/yyyy) _____

Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U

If yes:

Specify: _____

Why was the patient tested for this condition? (Select all that apply)

- Symptomatic of disease
- Screening of asymptomatic person with reported risk factor(s)
- Exposed to organism causing this disease (asymptomatic)
- Elevated liver enzymes

- Household/close contact to a person reported with this disease
- Follow-up for previous marker for viral hepatitis
- Other, specify: _____
- Unknown

Was patient hospitalized for this illness >24 hours? Y N U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) ____ - _____

Admit date (mm/dd/yyyy): ___/___/___

Discharge date (mm/dd/yyyy): ___/___/___

Restrictions to movement or freedom of action? Y N

Check all that apply:

- Work
- Sexual behavior
- Child care
- Blood and body fluid
- School
- Other, specify _____

Date control measures issued: _____

Date control measures ended: _____

Was patient compliant with control measures? Y N

Discharge/Final diagnosis: _____

Did patient have a travel history during the 50 days before onset of symptoms? Y N U

List travel dates and destinations _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

List persons and contact information: _____

In the 3 months prior to symptom onset, did anyone in the patient's household travel outside the United States or Canada? Y N U

Name of traveler _____

Dates of travel: from _____ to _____

Destination _____

Additional travel/residency information:

(CONTINUED NEXT PAGE)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS PART 2 WIZARD (CONTINUED)
COMMUNICABLE DISEASE

Patient wears diapers or shares a classroom with diapered children? Y N U
 Who wears diapers?
 Patient Classmate
 Give names of all child health care arrangements attended by the patient that involve diapering (patient wears diapers or other children in the same group wear diapers).

Patient a child care worker or volunteer in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (____) _____

Patient a parent or primary caregiver of a child in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (____) _____

Is patient a student? Y N U
 Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (____) _____
 Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U
 Type of school
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Telephone: (____) _____

Does the patient know anyone else with similar symptoms? Y N U
 Specify _____

During the 50 days before onset of symptoms did the patient have contact with sewage or human excreta? Y N U

During the period of interest, was the patient:
Employed as food worker? Y N U
 Where employed? _____
 Specify job duties: _____
 What dates did the patient work?

Employed as food worker during the contagious period? Y N U
 Where did the patient work? _____
 What dates did the patient work?

Non-occupational food worker (e.g. potlucks, receptions) during contagious period? Y N U
 Where employed? _____
 Specify dates and locations worked during contagious period:

Health care worker or child care worker handling food or medication in the contagious period? Y N U
 Where employed?
 Specify dates and locations worked during contagious period:

Has the patient ever received vaccine (including Twinrix) **related to this disease?** Y N U
 If yes, list date(s) and type(s)/manufacturer of all doses:
 1) _____

 2) _____

TREATMENT

Has the patient ever received immune globulin? Y N U
If yes, when was the last dose received? (mm/dd/yyyy): _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) Y N
 If yes, specify: _____

Were written isolation orders issued? Y N
 If yes, where was the patient isolated? _____

 Date isolation started? _____
 Date isolation ended? _____
 Was the patient compliant with isolation? Y N

Were written quarantine orders issued? Y N
 If yes, where was the patient quarantined?

 Date quarantine started? _____
 Date quarantine ended? _____
 Was the patient compliant with quarantine? Y N

CLINICAL OUTCOMES

Survived? Y N U
Died? Y N U
Died from this illness? Y N U
 Date of death (mm/dd/yyyy): ____/____/____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 50 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U
 Name of facility: _____
 Dates of contact: _____

During the 50 days before onset of symptoms until 7 days after onset of jaundice, did the patient attend social gatherings or crowded settings? Y N U
 If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

During the 50 days before onset of symptoms:
Did the patient use injection drugs not prescribed by a doctor? Y N U
Did the patient use NON-injection street drugs? Y N U
Did the patient have sexual contact with a confirmed or suspected case of this disease? Y N U
Did the patient have sexual contact with a FEMALE? Y N U
 If yes:
 Specify number of female partners: _____
Did the patient have sexual contact with a MALE? Y N U
 If yes:
 Specify number of male partners _____

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						SSN / /

FOOD RISK AND EXPOSURE

During the 50 days prior to onset of symptoms, did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? Y N U

Specify type of seafood/shellfish _____
Specify place of exposure _____

Describe the source of drinking water used in the patient's home (check all that apply):
 Bottled water supplied by a company
 Bottled water purchased from a grocery store
 Municipal supply (city water)
 Well water

Specify type/brand _____

Where does the patient/patient's family typically buy groceries?
 Store name: _____
 Store city: _____
 Shopping center name/address: _____

During the 50 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? Y N U

Specify source: _____

Eat any food items that came from a store or vendor where they do not typically shop for groceries? Y N U

Specify source(s): _____

Drink unpasteurized juices or ciders? Y N U

Specify juices or ciders:
 Apple
 Orange
 Other, specify: _____

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)? Y N U
 Handle/eat clams? Y N U
 Handle/eat crabs? Y N U
 Handle/eat lobster? Y N U
 Handle/eat mussels? Y N U
 Handle/eat oysters? Y N U
 Handle/eat shrimp? Y N U
 Handle/eat crawfish? Y N U
 Handle/eat other shellfish? Y N U

Eat raw fruit? Y N U

Specify raw fruit:
 Apples
 Bananas
 Oranges
 Grapes, specify: _____
 Pears
 Peaches
 Berries, specify _____
 Melon, specify _____
 Mangoes
 Other, specify: _____

Eat raw salads or vegetables other than sprouts? Y N U

Specify raw salad or vegetable:
 Bagged salad greens without toppings, type: _____
 Salad with toppings, specify: _____
 Lettuce, type: _____
 Spinach
 Tomatoes, type: _____
 Cucumbers
 Mushrooms, type: _____
 Onions, type: _____
 Potatoes, type: _____
 Other, specify: _____

Eat sprouts? Y N U

Specify type of sprouts:
 Alfalfa Clover Bean
 Other, specify: _____
 Unknown

Eat fresh herbs? Y N U

Specify:
 Basil Thyme
 Parsley Cilantro
 Oregano Rosemary
 Cumin
 Other, specify: _____

Eat potentially hazardous foods (i.e. pastries, custards, salad dressings)? Y N U

Specify:
 Pastries
 Custards
 Salad dressings
 Other: specify _____

Eat commercially-prepared, refrigerated foods (i.e. dips, salsa, sandwiches)? Y N U

Specify type of food:
 Dips, specify: _____
 Salsa
 Sandwiches, Specify: _____
 Other, Specify: _____

Eat at a group meal? Y N U

Specify:
 Place of Worship
 School:
 Social function
 Other, Specify: _____

Eat food from a restaurant? Y N U

Name: _____
 Location: _____

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown

Is the patient part of an outbreak of this disease? Y N

Notes regarding setting of exposure:

Hepatitis A

2000 CDC Case Definition

Clinical description

An acute illness with:

- discrete onset of symptoms, **and**
- jaundice or elevated serum aminotransferase levels

Laboratory criteria for diagnosis

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive

Case Classification

Confirmed

- a case that meets the clinical case definition and is laboratory confirmed
- a case that meets the clinical case definition and occurs in a person who has an epidemiologic link with a person who has laboratory-confirmed hepatitis A (i.e., household or sexual contact with an infected person during the 15-50 days before the onset of symptoms).