COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT
Acute Hepatitis C Questionnaire

For confirmed, probable & suspected cases of acute hepatitis C
{Questions marked with a * are those that must be entered into the CEDRS record}

***Patient Name___________________________________CEDRS # _____________**
***Address_______________________________________*Phone (hm) __________**
***City ______________ *County__________ *ZIP_______*Phone (wk)___________**
***DOB______________*Age (years)__________ *Sex: M F**
***Date reported to public health ___/____/____**

***CONSENT:** All of your responses will be handled in a confidential manner to the extent allowed by the law. **Date this statement was verbally told to the patient:** ___/ ___/___

*DEMOGRAPHIC INFORMATION:

***Race:** (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other race
If other, please specify _______________
***Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown
***Place of birth:** ☐ USA ☐Other country:_________________
***Physician:** (name, address, and phone number)__________________________________
____

*CLINICAL AND DIAGNOSTIC DATA:

***Reason for testing:** (check all that apply)

☐ Asymptomatic patient with no risk factors ☐ Prenatal
☐ Asymptomatic patient with risk factors ☐ Symptoms of acute hepatitis
☐ Blood/organ donor screening ☐ Unknown
☐ Evaluation of elevated liver enzymes ☐ Other (specify)______________
☐ Follow-up testing for previous marker of viral hepatitis

*CLINICAL DATA / SYMPTOMS:

***Diagnosis date:** ___/___/______
***Is or was patient symptomatic?** ☐ Yes ☐ No ☐ Unknown
***If yes,** onset date: ___/___/____
***Did the patient experience? (answer for each symptom below)**

Abdominal Pain	☐ Yes ☐ No ☐ Unk	**Fever**	☐ Yes ☐ No ☐ Unk
Arthralgia	☐ Yes ☐ No ☐ Unk	**Jaundice**	☐ Yes ☐ No ☐ Unk
Clay Colored Stool	☐ Yes ☐ No ☐ Unk	**Loss of Appetite**	☐ Yes ☐ No ☐ Unk
Dark Urine	☐ Yes ☐ No ☐ Unk	**Nausea**	☐ Yes ☐ No ☐ Unk
Diarrhea	☐ Yes ☐ No ☐ Unk	**Vomiting**	☐ Yes ☐ No ☐ Unk
Fatigue	☐ Yes ☐ No ☐ Unk		

*** Patient hospitalized for hepatitis?** ☐ Yes ☐ No ☐ Unknown

*** Patient currently pregnant?** ☐ Yes ☐ No ☐ Unknown
Due date: ___ /___/_____

***Did the patient die from hepatitis?** ☐ Yes ☐ No ☐ Unknown **Date of death ___/___/___**

***DIAGNOSTIC TESTS:**

***Date when (1st) blood drawn for hepatitis B testing?** ___/___/___

***Reporting Laboratory**____

***HAV/HBV/HCV serology results: start below (check all that apply)**

***Total antibody to hepatitis A virus [total anti-HAV]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done

***IgM antibody to hepatitis A virus [IgM anti-HAV]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done

***Hepatitis B surface antigen [HBsAg]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done

***Total antibody to hepatitis B core antigen [total anti-HBc]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done

***IgM antibody to hepatitis B core antigen [IgM anti-HBc]**
☐ Positive ☐ Negative ☐ Unknown ☐ Borderline ☐ Not done

* **Antibody to hepatitis C virus [anti-HCV]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done
***anti - HCV signal to cut-off ratio**_____________

***Supplemental anti-HCV assay [e.g., RIBA]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done

***HCV RNA [e.g., PCR]**
☐ Positive ☐ Negative ☐ Unknown ☐ Not done

***Liver enzyme values:**
***SGPT (ALT)** __________ Test date: ___/___/____ Upper limit normal: _______
***SGOT (AST**) __________ Test date: ___/___/____ Upper limit normal: _______
Other tests ____

***VACCINATION HISTORY:**

***Has the patient ever received hepatitis A vaccine?** ☐ Yes ☐ No ☐ Unk
If yes, how many doses? ☐ 1 ☐ ≥ 2
Year of the last Hepatitis A dose: _________

***Has the patient ever received hepatitis B vaccine?** ☐ Yes ☐ No ☐ Unk
If yes, how many doses? ☐ 1 ☐ 2 ☐ 3+
Year of the last Hepatitis B dose:________

***Was the patient ever given Immune Globulin?** ☐ Yes ☐ No ☐ Unk
If yes, what **month/year** was the last dose received? ___/___.

*PATIENT INFORMATION/HISTORY:

***During the 2 *weeks – 6 months* prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection?**
□ Yes □ No □ Unk **If yes**, was the contact: (check all that apply)
□ Donor □ Household Member (non-sexual) □ IDU □ Nosocomial □ Occupational
□ Other □ Perinatal □ Sex Partner □ Unknown
If other, please specify ____

***In the *6 months* before symptom onset,**
(Ask both of the following questions regardless of the patient's gender)

	0	1	2-5	>5	Unk
How many male sex partners did the patient have?	□	□	□	□	□
How many female sex partners did the patient have?	□	□	□	□	□

*Of the sex partners you had during the last 6 months how many did you find through the intranet? ________Total #

***Was the patient *EVER* treated for a sexually transmitted disease?**
□ Yes □ No □ Unk
If yes, which disease(s):____
What was the **year** of most recent treatment:____________________________

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

1. *Did the patient inject drugs not prescribed by a doctor? □ Yes □ No □ Unk
   If yes, what was patient's drug of choice? ________________________

2. *Did the patient use street drugs (not injected)? □ Yes □ No □ Unk
   If yes, what was patient's drug of choice? _________________________

3. *Undergo hemodialyisis? □ Yes □ No □ Unk
If yes, **month and year** of hemodialysis ____________________________

4. *Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? □ Yes □ No □ Unk

5. *Did the patient receive blood or blood products [transfusion]? □ Yes □ No □ Unk
If yes, date of transfusion? (___/___/____)

6. ***Did the patient receive any outpatient IV infusions and/or injections?
□ Yes □ No □ Unk

7. Patient diabetic? □ Yes □ No □ Unk
If yes, has patient shared diabetic supplies? □ Yes □ No □ Unk

8. *Did the patient have other exposure to someone else's blood? □ Yes □ No □ Unk
If yes, please specify____

9. *Was the patient employed in a medical or dental field involving direct contact with human blood? □ Yes □ No □ Unk
If yes, **what was the frequency of the direct blood contact?** □ Frequent (several times weekly) □ Infrequent

10. *Was the patient employed as a public safety worker having direct contact with human blood? □ Yes □ No □ Unk
If yes, please specify □ Correctional Office □ Fire Fighter □ Law Enforcement Officer □ Other
What was the frequency of the direct blood contact? □ Frequent (several times weekly) □ Infrequent

11. *Did the patient receive a tattoo? □ Yes □ No □ Unk
If yes, where was the tattooing performed? (check all that apply)
□ Commercial Parlor/Shop □ Correctional Facility □ Other
If other, please list___________________

12. *Did the patient have any part of their body pierced (other than ear)?
□ Yes □ No □ Unk
If yes, where was the piercing performed? (check all that apply)
□ Commercial Parlor/Shop □ Correctional Facility □ Other
If other, please list___________________

13. *Did the patient have dental work or oral surgery? □ Yes □ No □ Unk

14. *Did the patient have surgery (other than oral)? □ Yes □ No □ Unk

15. * Was the patient hospitalized during the incubation period? □ Yes □ No □ Unk

16. *Was the patient a resident of a long-term care facility (i.e., Nursing Home)?
□ Yes □ No □ Unk

17. *Was the patient a resident of an inpatient drug treatment program? □ Yes □ No □ Unk

18. *Was the patient a resident of a half-way house? □ Yes □ No □ Unk

19. *Was the patient incarcerated for longer than 24 hours? □ Yes □ No □ Unk
If yes, what type of facility? □ Jail □ Juvenile Facility □ Prison

20. * During his/her lifetime, was the patient **ever** incarcerated for longer than 6 months?
□ Yes □ No □ Unk
If yes, what year was the most recent incarceration? _______ For how long? __________

21. *Patient **EVER** have clotting factor? (enter year) ________

22.*Patient **EVER** have an organ transplant (any type)? ________(enter year)

♦ Information from questions marked with a * should be entered into CEDRS. If unable to enter record into CEDRS surveillance form can be faxed to Sandy Rios at 303-759-5257. ♦ Questions contact Candace Vonderwahl (303.692.2687) or Sandy Rios (303.692.2965).

Additionally, please complete CASE MANAGEMENT page (page 5) and fax to Sandy Rios at 303-759-5257.

HEPATITIS C / CASE MANAGEMENT:

Case Name: ____CEDRS#:_____________

1. **Patient** referred for HIV testing? ☐ Yes ☐ No
2. **Patient** referred for hepatitis A & B vaccine (if not vaccinated)? Yes ☐ No ☐
3. Total number of **contacts** referred for hepatitis C testing. ______
4. Total number of **contacts** referred for hepatitis A and B vaccine. ______

CONTACTS							
Name of Contact	**Age/ DOB**	**Locating Information Phone/Address**	**Type of Exposure** (IVDU, blood exposure, sex)	**Exposure Date m/d/yr**	**HCV tested? Y/N & where?**	**Lab Date & Result**	**Vaccinated? Y/N Date & where?**
1.							
2.							
3.							
4.							

NOTES:

Interviewer Name: _________________________ ***Interview Date:*** ___/___/___

Agency: ____

Fax page 5 to Sandy Rios, Viral Hepatitis Program 303-759-5257