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 ___/____/____**

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

8. *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

9. *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

10. *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___________________

11. *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___________________

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

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

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

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

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

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

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

19. * 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? __________

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

21.*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 303-691-7753. ♦ 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 303-691-7753.

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 303-691-7753