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:_____
_____
The patient is:
☐ Resident of NC
☐ Resident of another state or US territory
☐ Foreign Visitor
☐ Refugee
☐ Recent Immigrant
☐ Foreign Adoptee
☐ None of the above
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:
Patient in child care? ☐Y ☐N ☐U
Name of care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County:_____
Contact name:_____
Telephone: (_____) _____

(CONTINUED NEXT PAGE)

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

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)

Patient wears diapers or shares a classroom with diapered children? ☐Y ☐N ☐
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?
☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University/College
☐ Camp
☐ Doctor's office/ Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency Department
☐ Laboratory
☐ Long-term care facility /Rest Home
☐ Military
☐ Prison/Jail/Detention Center
☐ Place of Worship
☐ Outdoors, including woods or wilderness
☐ Athletics
☐ Farm
☐ Pool or spa
☐ Pond, lake, river or other body of water
☐ Hotel / motel
☐ Social gathering, other than listed above
☐ Travel conveyance (airplane, ship, etc.)
☐ International
☐ Community
☐ Other (specify) _____
☐ Unknown

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 _____

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

2012 Case Definition

CSTE Position Statement Number: 11-ID-02

Clinical Description

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and either a) jaundice, or b) elevated serum aminotransferase (alanine aminotransferase or aspartate 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, OR
- 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)