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

HEPATITIS C, ACUTE

Confidential Communicable Disease Report—Part 2

NC DISEASE CODE: 60

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

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.

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:
Fatigue/malaise/weakness ☐ Y ☐ N ☐ U
Loss of appetite (anorexia) ☐ Y ☐ N ☐ U
Weight loss with illness ☐ Y ☐ N ☐ U
Nausea ☐ Y ☐ N ☐ U
Vomiting ☐ Y ☐ N ☐ U
Abdominal pain or cramps ☐ Y ☐ N ☐ U
Joint pain ☐ Y ☐ N ☐ U
Enlarged liver (hepatomegaly) ☐ Y ☐ N ☐ U
Elevated liver enzymes ☐ Y ☐ N ☐ U
(ALT>400 IU/L)
If yes, specify level:____________________
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:____________________
Tested for IgM anti-HAV? ☐ Y ☐ N ☐ U
If yes, results: ☐ positive ☐ negative
Tested for IgM anti-HBc? ☐ Y ☐ N ☐ U
If yes, results: ☐ positive ☐ negative

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U
Specify ______________________________

REASON FOR TESTING

Why was the patient tested for this condition? (Select all that apply)
☐ Symptoms of acute hepatitis
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Elevated liver enzymes
☐ Blood/organ/tissue donor screening
☐ Follow-up for previous marker for viral hepatitis
☐ Blood/body fluid exposure
☐ Healthcare exposure
☐ Other, specify:______________________
☐ Unknown

HOSPITALIZATION INFORMATION

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):____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

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
Did local health director or designee implement additional control measures? ☐ 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

CLINICAL OUTCOMES

Discharge/Final diagnosis:____________________
Survived? ☐ Y ☐ N ☐ U
Died? ☐ Y ☐ N ☐ U
Died from this illness? ☐ Y ☐ N ☐ U
Date of death (mm/dd/yyyy):_____/_____/_____

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

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ None of the above

Notes:

HEALTH CARE FACILITY AND BLOOD & BODILY FLUID EXPOSURE RISKS

From 2 weeks to 6 months prior to onset of symptoms/illness did the patient have any of the following healthcare facility exposures?

Patient was hospitalized.................. ☐ Y ☐ N ☐ U

Patient was a resident of a long term care facility (e.g., nursing home, rest home, rehab).. ☐ Y ☐ N ☐ U

Patient underwent dialysis .... ☐ Y ☐ N ☐ U

If yes:

Facility Name ____________________________

City ____________________________________

State__________Country__________________

Patient had puncture or accidental stick with a needle or other object known to be or possibly contaminated with blood .... ☐ Y ☐ N ☐ U

Received blood or blood products (transfusion).................................. ☐ Y ☐ N ☐ U

Date received (mm/dd/yyyy)________________

☐ Date unknown

Facility or Provider name __________________

Address ______________________________

Contact name __________________________

Received any IV infusions (other than blood/blood product transfusions) and/or injections in an outpatient setting............................ ☐ Y ☐ N ☐ U

Patient had dental work or oral surgery.................................... ☐ Y ☐ N ☐ U

Other surgery (besides oral surgery), obstetrical or invasive procedure......................... ☐ Y ☐ N ☐ U

Was patient employed in a medical or dental field involving direct contact with human blood? .... ☐ Y ☐ N ☐ U

Was frequency of direct blood contact
- ☐ Frequent (several times weekly)
- ☐ Infrequent
- ☐ Unknown

Did the patient have other blood and/or body fluid exposure?.............................. ☐ Y ☐ N ☐ U

Have non-healthcare related exposure to someone else's blood? .... ☐ Y ☐ N ☐ U

Specify ________________________________

Was patient employed as a public safety worker (firefighter, law enforcement, or correctional officer) having direct contact with human blood? .... ☐ Y ☐ N ☐ U

If yes, was frequency:
- ☐ Frequent (several times weekly)
- ☐ Infrequent
- ☐ Unknown

Notes:

BEHAVIORAL RISK AND CONGREGATE LIVING

During the 6 months 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: ___________________________

Has the patient ever been incarcerated longer than 24 hours? .... ☐ Y ☐ N ☐ U

Indicate all facilities that apply:
- ☐ Jail ☐ Juvenile
- ☐ Prison ☐ Unknown

Has the patient ever been incarcerated for longer than 6 months?............. ☐ Y ☐ N ☐ U

Year of most recent incarceration of longer than 6 months:___________

Date of most recent incarceration of longer than 6 months:___________

Has the patient ever received any tattoos?.. ☐ Y ☐ N ☐ U

If yes, where was the tattoo performed?
- ☐ Commercial parlor/shop, specify name:__________________________
- ☐ Correctional facility
- ☐ Other, specify______________________
- ☐ Unknown

Has the patient received any piercings (other than ears)**?** .... ☐ Y ☐ N ☐ U

If yes, where was the piercing performed?
- ☐ Commercial parlor/shop, specify name:_____________________________
- ☐ Correctional facility
- ☐ Other, specify______________________
- ☐ Unknown

Has the patient ever used injection drugs not prescribed by a doctor? .... ☐ Y ☐ N ☐ U

Has the patient ever used NON-injection street drugs? .... ☐ Y ☐ N ☐ U

Has the patient had sexual contact with a known or suspected case of this disease? ... ☐ Y ☐ N ☐ U

Has the patient ever been diagnosed with a sexually transmitted disease (STD)? .... ☐ Y ☐ N ☐ U

Indicate year of last STD treatment: _________

During the 6 months prior to symptom onset, has the patient had sexual contact with a FEMALE? .... ☐ Y ☐ N ☐ U

If yes, specify number of female partners__________

During the 6 months prior to symptom onset, has the patient had sexual contact with a MALE?.. ☐ Y ☐ N ☐ U

If yes, specify number of male partners___________

In what setting was the patient most likely exposed?

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

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? .... ☐ Y ☐ N ☐ U

Specify _______________________________

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:

Hepatitis C, acute

2007 CDC Case Definition

Clinical description

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., anorexia, abdominal discomfort, nausea, vomiting), and either a) jaundice, or b) serum alanine aminotransferase (ALT) levels >400 IU/L.

Laboratory criteria for diagnosis

One or more of the following three criteria:

1. Antibodies to hepatitis C virus (anti-HCV) screening-test-positive with a signal to cut-off ratio predictive of a true positive as determined for the particular assay as defined by CDC. (URL for the signal to cut-off ratios: http://www.cdc.gov/ncidod/diseases/hepatitis/c/sc_ratios.htm),

   OR

2. Hepatitis C Virus Recombinant Immunoblot Assay (HCV RIBA) positive,

   OR

3. Nucleic Acid Test (NAT) for HCV RNA positive

AND, meets the following two criteria:

1. IgM antibody to hepatitis A virus (IgM anti-HAV) negative,

   AND

2. IgM antibody to hepatitis B core antigen (IgM anti-HBc) negative

Case classification

Confirmed: a case that meets the clinical case definition, is laboratory confirmed, and is not known to have chronic hepatitis C.