Reset Form

VIRAL HEPATITIS B & C CASE REPORT FORM

State Form 57576 (R / 3-25)
INDIANA DEPARTMENT OF HEALTH

Indiana Department of Health
HIV/STI/Viral Hepatitis
2 N Meridian St
Indianapolis, Indiana 46204
Fax: (317) 233-7663

INSTRUCTIONS: 1. Please fill out form and fax back

PATIENT DEMOGRAPHICS

Patient Name
First: _____ Last: _____ Middle: _____

DOB:
__ __ /__ __/__ __ __ __

Sex:
☐ Male ☐ Female ☐ Unknown
☐ Choose not to answer

Pregnant?: ☐ Yes ☐ No
Due Date: __ __ /__ __ /__ __ __ __

Patient Address and Phone

Address: _____ City: _____

County: _____ ZIP: _____ Phone: _____

Race: ☐ Amer Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown

Country of Birth: ☐ USA ☐ Other: _____

Sexual Orientation: ☐ Bisexual ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Other: _____

REASON FOR TESTING

Reason for Testing (check all that apply)

☐ Year of birth (1945-1965)
☐ Symptoms of acute hepatitis
☐ Evaluation of elevated liver enzymes
☐ Prenatal Screening (EDD: __ __ /__ __ /__ __ __ __)
☐ Screening of asymptomatic patient w/ risk factors
☐ Screening of asymptomatic patient w/out risk factors
☐ Follow-up testing (previous viral hepatitis marker)
☐ Other: _____

CLINICAL INFORMATION

***Is patient aware of positive test results?** ☐ Yes ☐ No ☐ Unknown **Diagnosis Date:** __ __ /__ __ /__ __ __ __

Yes	No	Unknown	
☐	☐	☐	Is patient symptomatic?
			Circle: Jaundice / Fatigue / Abdominal pain / Nausea / Dark Urine / Other: _____
☐	☐	☐	Did the patient die from hepatitis?
☐	☐	☐	Does the patient have diabetes?
☐	☐	☐	Was the patient hospitalized for hepatitis?
☐	☐	☐	Has the patient completed the Hepatitis A vaccine series?
☐	☐	☐	Has the patient completed the Hepatitis B vaccine series?
			If patient was recently vaccinated for hepatitis B, please provide date: __ __ /__ __ /__ __ __ __
☐	☐	☐	If experiencing jaundice and/or elevated LFTs, is there a more likely diagnosis than acute viral hepatitis?
			***If yes,** please specify:* _____

DIAGNOSTIC INFORMATION

Lab Results

Collection Date	Positive	Negative	Unknown	
__ __ /__ __ /__ __ __ __	☐	☐	☐	IgM antibody to hepatitis A virus [**IgM anti-HAV**]
__ __ /__ __ /__ __ __ __	☐	☐	☐	Hepatitis B surface antigen [**HBsAg**]
				If positive, has **HBsAg** been confirmed? ☐ Yes ☐ No ☐ Unknown
__ __ /__ __ /__ __ __ __	☐	☐	☐	Hepatitis B "e" antigen [**HBeAg**]
__ __ /__ __ /__ __ __ __	☐	☐	☐	**Hepatitis B DNA** [e.g. Hep B NAT, DNA, PCR]
__ __ /__ __ /__ __ __ __				**HBV Genotype** [e.g. A, B1…J] _____
__ __ /__ __ /__ __ __ __	☐	☐	☐	Total antibody to hepatitis B core antigen [**total anti-HBc**]
__ __ /__ __ /__ __ __ __	☐	☐	☐	IgM antibody to hepatitis B core antigen [**IgM anti-HBc**]

Lab Results cont.

__ __ /__ __ /__ __ __ __ ☐ ☐ ☐ Antibody to hepatitis D virus [**anti-HDV**]

__ __ /__ __ /__ __ __ __ ☐ ☐ ☐ Hepatitis **D RNA** [e.g., NAT, PCR]

__ __ /__ __ /__ __ __ __ ☐ ☐ ☐ Antibody to hepatitis C virus [**anti-HCV**]
Signal to cut-off ratio _____

__ __ /__ __ /__ __ __ __ ☐ ☐ ☐ **HCV RNA** [e.g., NAT, PCR, TMA]

__ __ /__ __ /__ __ __ __ **HCV Genotype** [e.g. 1a, 1b...3] _____

Collection Date

__ __ /__ __ /__ __ __ __ ALT [SGPT] (Alanine aminotransferase) Result _____ Upper Limit Normal _____

__ __ /__ __ /__ __ __ __ AST [SGOT] (Aspartate aminotransferase) Result _____ Upper Limit Normal _____

__ __ /__ __ /__ __ __ __ Total Bilirubin Result _____

ADDITIONAL INFORMATION

Risk Factor Information

Ever		Last 6 months		
Yes	No	Yes	No	
☐	☐	☐	☐	Used a needle to inject drugs?
☐	☐	☐	☐	**If yes**, shared needles, syringes, or other equipment?
☐	☐	☐	☐	Snorted or smoked drugs?
☐	☐	☐	☐	**If yes,** shared drug use equipment?
☐	☐	☐	☐	Experienced incarceration for longer than 24 hours?
☐	☐	☐	☐	**If yes,** Jail?
☐	☐	☐	☐	**If yes,** Prison?
☐	☐	☐	☐	**If yes,** Juvenile Facility?
☐	☐	☐	☐	Contact with someone living with viral hepatitis?
☐	☐	☐	☐	**If yes,** sexual contact?
☐	☐	☐	☐	**If yes,** household contact?
☐	☐	☐	☐	**If yes,** other contact? Specify: _____
☐	☐	☐	☐	Received tattoo(s) or piercings(s)? **If yes,** circle: Commercial Non-Commercial
☐	☐	☐	☐	Worked in medical or dental field involving direct contact with human blood?
☐	☐	☐	☐	Had multiple sex partners? Number of partners: Male_____ Female_____
☐	☐	☐	☐	Experienced homelessness and/or unstable housing?
		☐	☐	Traveled internationally? **If yes,** which countries: _____
☐	☐			Does the patient identify as MSM (men who have sex with men)?

Transplant Information

Yes	No	Unknown	
☐	☐	☐	Did the patient receive an organ or tissue transplant?

If yes, please attach viral hepatitis testing records pre- and post-transplant

If yes, transplant date: __ __ /__ __ /__ __ __ __

Hepatitis C Treatment Information

Yes	No	Unknown	
☐	☐	☐	Did the patient receive treatment for a prior HCV infection?

If yes, treatment date: __ __ /__ __ /__ __ __ __

☐	☐	☐	Did the patient begin treatment for current HCV infection?

If yes, treatment start date: __ __ /__ __ /__ __ __ __

If yes, treatment end date: __ __ /__ __ /__ __ __ __

ADDITIONAL NOTES

REPORTER & PROVIDER INFORMATION		
Reporting Organization:		
Reporting Organization Address:		
Reporting Organization Phone Number:	Fax Number:	
Provider Name:	Provider Phone Number:	
Signature of Reporter		Date
Printed name of Reporter	Title	