HEPATITIS C CASE INVESTIGATION - Page 1 of 9
Indiana State Department of Health
State Form 52588 (R2/11-09)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN
1. Type all data into form
2. Provide as much information as possible
3. Print copy for faxing to ISDH
4. Fax copy to Epidemiology Resource Center, ISDH
5. Date format: MM/DD/YYYY

Section 1: Demographics

First:
Middle:
Last:

If child, parent name (below):

First:
Middle:
Last:

Maiden Name:
Mother's Maiden:
Street Address:
City:
State: --Select State--
Zip:
County: --Select County--
Phone Number: --Type--
Date of Birth: ☐ Unknown
OR
Age: Years
SSN:
Gender: --Select Gender--
Race(s):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other/Multiracial
☐ Unknown
☐ White
Ethnicity: --Select Ethnicity--
Physician's Name:
Phone Number:
Fax Number:
Street Address:
City:
State: --Select State--
Zip:

Section 1: Demographics (continued)

Occupation: --Select--

Employer Name:

Phone Number:

Street Address:

City:

State: --Select State--

County: --Select County--

Zip:

Section 2: Clinical

Health Care Provider:

Facility Type: --Select--

Facility:

Street Address:

City:

State: --Select State--

Zip:

Phone Number:

Date of onset:

Date of diagnosis:

Duration of symptoms: Days

Date of first positive specimen:

Genotype: --Select--

Symptoms:

- ☐ Fever
  0 Degrees (F)
- ☐ Abdominal Pain
- ☐ Dark urine
- ☐ Diarrhea
  Onset Date:
- ☐ Fatigue
- ☐ Jaundice
- ☐ Loss of appetite
- ☐ Pale stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Other
  Specify:

Section 2: Clinical (continued)

Reason for testing:

- ☐ Symptoms of acute hepatitis
- ☐ Evaluation of elevated liver enzymes
- ☐ Screening of asymptomatic patient with reported risk factors
- ☐ Blood donor screening
- ☐ Organ donor screening
- ☐ Plasma donor
- ☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- ☐ Follow-up testing for previous marker of viral hepatitis
- ☐ Prenatal screening
- ☐ Immigrant screening
  - Specify Country:
- ☐ Other reason
  - Specify:

Screening Tests:

Antibody to hepatitis C virus (anti-HCV):
☐ Positive ☐ Negative ☐ Not Done/Unknown
List signal to cut-off ratio:

Total antibody to hepatitis A virus (Total anti-HAV):
☐ Positive ☐ Negative ☐ Not Done/Unknown

lgM antibody to hepatitis A virus (lgM anti-HAV):
☐ Positive ☐ Negative ☐ Not Done/Unknown

Hepatitis B surface antigen (HBsAg):
☐ Positive ☐ Negative ☐ Not Done/Unknown

Total antibody to hepatitis B core antigen (Total anti-HBc):
☐ Positive ☐ Negative ☐ Not Done/Unknown

lgM antibody to hepatitis B core antigen (lgM anti-HBc):
☐ Positive ☐ Negative ☐ Not Done/Unknown

Confirmatory Tests:

Supplemental anti-HCV assay (e.g., RIBA, Immunoblot):
☐ Positive ☐ Negative ☐ Not Done/Unknown

HCV RNA (e.g., PCR, bDNA, TMA):
☐ Positive ☐ Negative ☐ Not Done/Unknown

Liver enzyme testing done?: ☐ Yes ☐ No ☐ Unknown

Liver enzyme levels at time of diagnosis:

ALT (SGPT) results:
Upper limit normal:
Date of ALT:

ALT (SGOT) results:
Upper limit normal:
Date of AST:

Is the patient co-infected with HIV? ☐ Yes ☐ No ☐ Unknown
Date:

Section 2: Clinical (continued)

Is the patient co-infected with HBV? ☐ Yes ☐ No ☐ Unknown
Date:

Was patient hospitalized for hepatitis C? ☐ Yes ☐ No ☐ Unknown

Admission Date:
Discharge Date:
Patient's Chart Number:
Facility Type: --Select--
Facility:
Street Address:
City:
State: --Select State--
Zip:
Phone Number:

Did patient die from hepatitis C complications? ☐ Yes ☐ No ☐ Unknown
Specify:
Date:

Section 3: Diagnosis

Please select one:
☐ Acute Hepatitis C
☐ Chronic Hepatitis C
☐ Resolved Hepatitis C Infection
☐ Unable to Determine
☐ Unable to Locate/No Response from Patient
☐ Not a Case

Patient education & Contact follow-up will be done by:
☐ Local Health Department
☐ Health Care Provider
☐ Clinic
☐ Other
Specify:

Section 4: Vaccination History

1. Did the patient ever receive hepatitis A vaccine?
☐ Yes ☐ No ☐ Unknown

Date:	Vaccine Type:	Manufacturer:	Lot Number:	Physician/Institution:

Section 4: Vaccination History (continued)

2. Did the patient ever receive hepatitis B vaccine?

☐ Yes ☐ No ☐ Unknown

Date:	Vaccine Type:	Manufacturer:	Lot Number:	Physician/Institution:

Section 5: Patient History (Acute and Chronic)

1. Was the patient ever a contact of a person with confirmed or suspected hepatitis C infection?

☐ Yes ☐ No ☐ Unknown

Contact Type:	Date:
--Select--	
--Select--	
--Select--	

2. Did the patient undergo hemodialysis?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

3. Was the patient ever incarcerated for longer than 24 hours?

☐ Yes ☐ No ☐ Unknown

Facility Type:	Facility Name:	Facility Location:	Date:
--Select--			
--Select--			
--Select--			

4. Was the patient ever employed as a healthcare worker with direct contact with human blood?

☐ Yes ☐ No ☐ Unknown

Type of work/occupation:

5. Was the patient ever employed as a public safety worker (fire fighter, law enforcement, correctional officer) having direct contact with human blood?

☐ Yes ☐ No ☐ Unknown

Type of work/occupation:

6. Was the patient ever employed in an occupation outside healthcare/public safety involving direct contact with human blood?

☐ Yes ☐ No ☐ Unknown

Type of work/occupation:

Section 5: Patient History (Acute and Chronic) (continued)

7. Did the patient ever inject drugs not prescribed by doctor (e.g. street drugs, steroids, hormones, vitamins, salon/spa injection)?

☐ Yes ☐ No ☐ Unknown

Type:	Date:	Type:	Date:
--Select--		--Select--	
--Select--		--Select--	
--Select--		--Select--	

8. Did the patient ever use street drugs but not inject?

☐ Yes ☐ No ☐ Unknown

Type:	Date:	Type:	Date:
--Select--		--Select--	
--Select--		--Select--	
--Select--		--Select--	

9. Was the patient ever treated for a sexually transmitted disease?

☐ Yes ☐ No ☐ Unknown

Last Treatment Date:

Section 6: Acute Only

In the last 6 months:

1. Did the patient receive blood or blood products (transfusion)?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

2. Did the patient receive any IV infusions/blood transfers and/or injections in an outpatient setting?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

3. Did the patient have any outpatient procedures (i.e. endoscopy, colonoscopy, etc.)?

☐ Yes ☐ No ☐ Unknown

Type:	Facility Location:	Date:

Section 6: Acute Only (continued)

4. Did the patient have dental work or oral surgery?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

5. Did the patient have surgery (other than oral surgery)?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

6. Was the patient hospitalized overnight for any reason?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

7. Was patient a resident of a long-term care facility?

☐ Yes ☐ No ☐ Unknown

Facility Name:	Facility Location:	Date:

8. Regardless of patient's gender list the number of sexual partners the patient has had?

Males: Females:

☐ None ☐ Unknown

9. Did the patient have a non occupational exposure to someone else's blood?

☐ Yes ☐ No ☐ Unknown

Specify:

Date:

10. Did the patient have any part of his/her body pierced (other than ear)?

☐ Yes ☐ No ☐ Unknown

Facility Type:	Facility Name:	Facility Location:	Date:
--Select--			
--Select--			
--Select--			

Section 6: Acute Only (continued)

11. Did the patient have an ear pierced?

☐ Yes ☐ No ☐ Unknown

Facility Type:	Facility Name:	Facility Location:	Date:
--Select--			
--Select--			
--Select--			

12. Did the patient have a tattoo placement?

☐ Yes ☐ No ☐ Unknown

Facility Type:	Facility Name:	Facility Location:	Date:
--Select--			
--Select--			
--Select--			

13. Did the patient have an accidental stick or puncture with a needle or other object (razor,clippers) contaminated with blood?

☐ Yes ☐ No ☐ Unknown

Object:	Facility Name:	Facility Location:	Date:

Section 7: Chronic Only

1. Is the patient a veteran?

☐ Yes ☐ No ☐ Unknown

2. Did the patient receive a blood transfusion prior to 1992?

☐ Yes ☐ No ☐ Unknown

3. Did the patient receive an organ transplant prior to 1992?

☐ Yes ☐ No ☐ Unknown

4. Did the patient receive clotting factor concentrates produced prior to 1987?

☐ Yes ☐ No ☐ Unknown

5. How many sex partners has the patient had in his/her lifetime?

Males: Females:

☐ None ☐ Unknown

Section 8: Comments

Interviewee:	--Select--
Specify:	
Interviewee's Name:	
Submitted by Agency:	
Investigator:	
Street Address:	
City:	
State:	--Select State--
Zip:	
Phone Number:	