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 C, ACUTE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 60

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
- ☐ 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

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

2012 Case Definition

CSTE Position Statement Number: 11-ID-05

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 alanine aminotransferase (ALT) levels >400IU/L.

*A documented negative HCV antibody laboratory test result followed within 6 months by a positive test (as described in the laboratory criteria for diagnosis) result does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory Criteria for Diagnosis

One or more of the following three criteria:

- 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/hepatitis/HCV/LabTesting.htm), OR
- Hepatitis C Virus Recombinant Immunoblot Assay (HCV RIBA) positive, OR
- Nucleic Acid Test (NAT) for HCV RNA positive (including qualitative, quantitative or genotype testing)

AND, if done meets the following two criteria:

- Absence of IgM antibody to hepatitis A virus (if done) (IgM anti-HAV), AND
- Absence of IgM antibody to hepatitis B core antigen (if done) (IgM anti-HBc)

Case Classification

Confirmed

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