

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:

\_\_\_\_\_

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Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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## NC EDSS PART 2 WIZARD (CONTINUED) COMMUNICABLE DISEASE

**Patient wears diapers or shares a classroom with diapered children?** ..... ☐ Y ☐ N ☐ U  
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?**

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

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## 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)