Last Name DOB MM/DD/YYYY

Please mail or fax completed forms to the patient's local health department (LHD).
To determine a patient's LHD, go to https://odhgateway.odh.ohio.gov/lhdinformationsystem/Directory/GetMyLHD.

Ohio Department of Health

Hepatitis B and Hepatitis C Case Collection Form

Patient Demographics

Date completed: MM / DD / YYYY

Last name	First name	Middle name	Alternative name(s)

Address (number and street)	City and state	Zip code	Phone number

Date of birth MM / DD / YYYY

Sex at birth ☐ Male ☐ Female

Current gender identity ☐ Male ☐ Female ☐ Transgender ☐ Unknown ☐ Other (specify): _____

Deceased? ☐ Yes ☐ No ☐ Unknown If YES, date of death: MM / DD / YYYY

If FEMALE, pregnant at diagnosis? ☐ Yes ☐ No ☐ Unknown If YES, delivery/due date: MM / DD / YYYY If NO, tubal ligation/hysterectomy? ☐ Yes ☐ No ☐ Unknown

Race (check all that apply)
☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Unknown
☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other (specify):

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Place of birth ☐ USA ☐ Other ☐ Unknown

Facility Information

Facility		Provider
Facility address	**Phone number**	**Facility type** ☐ Hospital ☐ Physician's office ☐ Laboratory ☐ Corrections ☐ Other (specify): _____

Clinical Information

Reason for testing (check all that apply)
☐ Screening of symptomatic patient
☐ Screening of patient with reported risk factors
☐ Screening of patient with NO risk factors
☐ Blood/organ donor screening
☐ Unknown
☐ Other (specify): _____
☐ Elevated liver enzymes
☐ Prenatal screening
☐ Post-vaccine serology
☐ Year of birth (1945-1965)

Has the patient received treatment for HCV? ☐ Yes ☐ No ☐ Unknown
If YES, complete the following:
Medication: _____
Treatment start date: MM / DD / YYYY
Treatment end date: MM / DD / YYYY
☐ Currently in treatment

Jaundice? (e.g., yellowing of skin or eyes) ☐ Yes ☐ No ☐ Unknown If YES, jaundice diagnosis date: MM / DD / YYYY

Laboratory Information

Has the patient EVER had a NEGATIVE hepatitis C test? ☐ Yes ☐ No ☐ Unknown
If YES, complete for NEGATIVE test(s): ☐ Anti-HCV (i.e. antibody, AB, AB+) Date: MM / DD / YYYY ☐ HCV RNA (i.e. PCR, quant, viral load) Date: MM / DD / YYYY ☐ HCV genotype Date: MM / DD / YYYY

Did the patient have an ALT test? ☐ Yes ☐ No ☐ Unknown
If YES, numeric result: _____ Date: MM / DD / YYYY

Did the patient have a Total Bilirubin test? ☐ Yes ☐ No ☐ Unknown
If YES, numeric result: _____ Date: MM / DD / YYYY

Did the patient have a hepatitis D test? ☐ Yes ☐ No ☐ Unknown
If YES, ☐ HDV antigen Date: MM / DD / YYYY ☐ HDV RNA (i.e. PCR, quant, viral load) Date: MM / DD / YYYY

Medical History

	YES	NO	Unknown
Does the patient have diabetes? If yes, date of diagnosis MM/DD/YYYY			
Did the patient receive blood or blood products (i.e. transfusion) BEFORE 1992?			
Did the patient receive an organ transplant BEFORE 1992?			
Did the patient receive clotting factor concentrate produced BEFORE 1987?			
Has the patient received the hepatitis B (HBV) vaccine?			

Last Name **DOB** MM/DD/YYYY

••••••••• If the patient is 36 months or younger, skip to Perinatal Exposure Information section. •••••••••

Epidemiology and Risk Factor Information

For the following questions, has the patient…	YES *Please mark a time frame.*			NO	Unknown
Injected drugs NOT prescribed by a doctor?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Used non-injection recreational drugs?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had contact with a person with Hepatitis C virus infection?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had contact with a person with Hepatitis B virus infection?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Been treated for a sexually-transmitted disease (STD)?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had sexual contact with a FEMALE?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had sexual contact with a MALE?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Been incarcerated for longer than 24 hours?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Received a tattoo?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Received a piercing (other than ear)?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had an accidental stick with an object contaminated with blood?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had any other exposure to someone else's blood?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had a period of homelessness?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had dental work (other than routine cleaning) or oral surgery?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had surgery (other than oral)?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Been hospitalized (prior to today for any reason)?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Undergone hemodialysis?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Had IV infusions or injections in the outpatient setting?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Received blood or blood products (i.e. transfusion)?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Been a resident of a long-term care facility?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Worked in a medical/dental field involving contact with blood?	Less than 6 mo ago	More than 6 mo ago	Not specified		
Worked in a public safety field involving contact with blood?	Less than 6 mo ago	More than 6 mo ago	Not specified		

Perinatal Exposure Information *(for patients 36 months or younger)*

Does the patient's biological mother have confirmed hepatitis B or C? ☐ Yes ☐ No ☐ Unknown

If YES, select type: ☐ Hepatitis B ☐ Hepatitis C ☐ Unknown

Biological mother's name: _____

Biological mother's date of birth: MM / DD / YYYY

Could the child have been exposed to hepatitis by means OTHER THAN mother-to-child transmission? ☐ Yes ☐ No ☐ Unknown

If YES, explain: _____

Additional Comments