

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>.



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Current gender identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____			
Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If FEMALE, pregnant at diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If YES, date of death: MM / DD / YYYY		If YES, delivery/due date: MM / DD / YYYY		If NO, tubal ligation/hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> African American <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other (specify): _____				Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
				Place of birth <input type="checkbox"/> USA <input type="checkbox"/> Other <input type="checkbox"/> Unknown	

Facility Information

Facility		Provider	
Facility address	Phone number ()	Facility type <input type="checkbox"/> Hospital <input type="checkbox"/> Physician's office <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Other (specify): _____	

Clinical Information

Reason for testing (check all that apply) <input type="checkbox"/> Screening of symptomatic patient <input type="checkbox"/> Screening of patient with reported risk factors <input type="checkbox"/> Screening of patient with NO risk factors <input type="checkbox"/> Blood/organ donor screening <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Elevated liver enzymes <input type="checkbox"/> Prenatal screening <input type="checkbox"/> Post-vaccine serology <input type="checkbox"/> Year of birth (1945-1965)		Has the patient received treatment for HCV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, complete the following: Medication: _____ Treatment start date: MM / DD / YYYY Treatment end date: MM / DD / YYYY <input type="checkbox"/> Currently in treatment	
Symptoms of acute hepatitis? (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, symptom onset date: MM / DD / YYYY					
Jaundice? (e.g., yellowing of skin or eyes) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, jaundice diagnosis date: MM / DD / YYYY					

Laboratory Information

Has the patient EVER had a NEGATIVE hepatitis C test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, complete for NEGATIVE test(s): <input type="checkbox"/> Anti-HCV (i.e. antibody, AB, AB+) <input type="checkbox"/> HCV RNA (i.e. PCR, quant, viral load) <input type="checkbox"/> HCV genotype Date: MM / DD / YYYY Date: MM / DD / YYYY Date: MM / DD / YYYY					
Did the patient have an ALT test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, numeric result: _____ Date: MM / DD / YYYY			Did the patient have a Total Bilirubin test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, numeric result: _____ Date: MM / DD / YYYY		

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

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?			

Epidemiology and Risk Factor Information

Last Name _____ DOB MM/DD/YYYY

For the following questions, has the patient...	YES <i>Please mark a time frame.</i>			NO	Unknown
	Less than 6 mo ago	More than 6 mo ago	Not specified		
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

