



Hepatitis A Case Report

Communicable Disease Control Directorate
 Fax: 9388 4848

Date:	/ /
Interviewer:	
Person interviewed (if not case):	
WANIDD number	WA 2 0 [] [] [] [] [] [] [] []
WANIDD updated?	/ /
Interpreter used?	<input type="checkbox"/> no
If yes, language:	<input type="checkbox"/> yes _____
Probable source	

This is a:
<input type="checkbox"/> Laboratory confirmed case - IgM
<input type="checkbox"/> Doctor's notification (Suspected current infection – probable case)
Outbreak no. (choose one): <input type="checkbox"/> not applicable
<input type="checkbox"/> Hepatitis A
019-200 ___ - _____

SECTION 1: DEMOGRAPHIC DATA

Surname: _____ Other names: _____
 Street address: _____
 Suburb/town: _____ Postcode: _____
 Telephone: H: () W: () Mobile: _____
 Date of birth: / / or Age: _____ Sex: male female
 Country of birth: _____ Language spoken at home: _____
 Of Aboriginal or Torres Strait Islander origin? no yes
 Occupation (incl. part-time/casual work): _____
 Name /address of employer or school or child care attended: _____
 Telephone: _____ Fax: _____
 Date last attended: / / High risk group?† no yes
e.g. those at high risk of transmitting hep A to others

† High risk groups include institutional residents, health care workers, food handlers, child care workers, children less than 6 years of age

SECTION 2: TREATING DOCTOR / HOSPITAL / LABORATORY

Name of treating Doctor: _____
 Hospital (if admitted): _____ UR No: _____
 Address: _____
 Telephone: _____ Facsimile: _____
 Date of admission / visit (circle appropriate one) / / Date of discharge/death / / not applicable
 Name of laboratory: _____ Telephone: _____
 Require doctor's notification no yes Patient informed by doctor no yes
 Confirmation of diagnosis serology serology pending clinical only
 Date of blood test : ___/___/___ Result: IgM –negative IgM+ve IgG-negative IgG+ve

SECTION 3: ILLNESS (SUMMARY)

Symptoms							
Fever	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	Dark Urine	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes, onset date: _____
Nausea	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	Body aches	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes
Vomiting	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	★Headache	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes
Abdominal pain	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes	★Diarrhoea	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes, onset date: _____ duration: _____
Jaundice	<input type="checkbox"/> no	<input type="checkbox"/> unknown	<input type="checkbox"/> yes, onset date: _____	Other (specify) _____ _____			

History of illness:
 Onset date of illness: ____/____/____ Time of onset:..... am / pm Total duration of illness:days

Immunisation details

Usual GP/Vax provider details: _____

Has case received Hepatitis A vaccination in the past?

- no
 unknown
 yes, if so provide details from doctor
 Dose 1: ____/____/____ date unknown
 Dose 2: ____/____/____ date unknown not given

Did case receive immunoglobulin (Ig) instead of vaccine?

- no
 unknown
 yes, date received ____/____/____

Validation of vaccination information

- Validated source/confirmed record. Please specify: ACIR DoHWA
 doctor/clinic
 Not validated - self or parental recall only
 Not known/no information

SECTION 7A: For all cases, please provide the following information

Exclusion required? <input type="checkbox"/> no <input type="checkbox"/> yes	If the case is in a high risk setting / occupation, they must be excluded from attendance / work until asymptomatic (diarrhoea has ceased and 7 days after onset of jaundice).
Exclusion discussed with case / parent / guardian. <input type="checkbox"/> no <input type="checkbox"/> yes	
Letter sent to contacts at premises? <input type="checkbox"/> no <input type="checkbox"/> yes	Date sent: ___/___/___
LGA informed? <input type="checkbox"/> no <input type="checkbox"/> yes	Contact date: ___/___/___ Contact name: Action required: Feed back received: <input type="checkbox"/> no <input type="checkbox"/> yes,

SECTION 7B: For cases in high risk groups only, please provide the following information

Name of related premises:	Date last attended: ___/___/___
Movements of case at work / CCC / institution:	
Date: ___/___/___	Day:..... Hours:..... Location:.....
Date: ___/___/___	Day:..... Hours:..... Location:.....
Date: ___/___/___	Day:..... Hours:..... Location:.....
Date: ___/___/___	Day:..... Hours:..... Location:.....
Date: ___/___/___	Day:..... Hours:..... Location:.....

SECTION 8: COMMENTS OR CONCLUSIONS

Comments:

<i>Signature:</i> _____	<i>Date:</i> ___/___/___
-------------------------	--------------------------

SECTION 9: CONTACT DATA† AND PROPHYLAXIS (for 2 weeks before to 2 weeks after onset of symptoms or 1 week after jaundice onset) ‡

A general list of persons considered to be contacts if exposed to infectious cases: immediate family, household members and sexual partners, including people who stayed and shared their primary bathroom facilities with the case; persons who consumed food not subjected to further cooking that was prepared by the case; if the case is a food handler, other food handlers in the same establishment; if the case is in nappies, persons who provided direct care to the case; if the case attends child care or preschool, other children and adults in the same classroom or care group.

- Monovalent hepatitis A vaccine is recommended for contacts over the age of 1 year who are not immunosuppressed, who have not had chronic liver disease diagnosed, and for whom vaccine is not contraindicated <http://www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-home> (page 146)
- NHIG is recommended to be reserved for the following contacts: <12 months of age; immunosuppressed; chronic liver disease; or for whom vaccine is contraindicated.

Index Case:

WA	2	0							
----	---	---	--	--	--	--	--	--	--

Indicate if a person in a high risk group has been identified:

Child Care Name: Contact person:

School

Other Phone:

High risk groups include institutional residents, health care workers, food handlers, child care workers, children less than 6 years of age

Name	Telephone	Previous HepA vaccination		Information	Parental consent				Referred to GP for prophylaxis					
		<input type="checkbox"/> N	<input type="checkbox"/> Y		<input type="checkbox"/>	IG		Hep A vaccine		IG		Hep A vaccine		serology
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y
		<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y

Community Nurse:		Telephone:	
Community Health Centre:		Date:	

