SURVEILLANCE OF VIRAL HEPATITIS – CASE INVESTIGATION FORM

EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

The Public Health Inspector should investigate and complete this form. Medical Officer of Health is responsible for the completeness and accuracy of data provided. Necessary data should be obtained from the patient, his/her relatives and from the diagnosis card. Early investigation and return are essential.

Week ending of notification ☐☐ ☐☐ ☐☐ (d d m m y y) | Serial No: ☐☐☐☐ * Please write the Serial No given in the Infectious Disease Register (ID Register) in the MOH Office

A. PARTICULARS OF PATIENT *(Please tick (✓) the appropriate box where applicable)*

1. Name of patient (BLOCK LETTERS) .....

2. Residential address: .....

3. Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

4. Age	5. Sex	6. Ethnic group	7. Occupation	8. DPDHS Division (district)	9. MOH area
☐☐/☐☐ (y y / m m)	☐ 1. male ☐ 2. female ☐ 3. not known	☐ 1. Sinhalese ☐ 2. Tamil ☐ 3. Moor ☐ 4. others ☐ 5. not known	.....	.....	.....
			FOR OFFICE USE ONLY		
			☐☐	☐☐	☐☐

B. PRESENT ILLNESS/OUTCOME

10. Date of onset of symptoms: ☐☐ ☐☐ ☐☐ (d d m m y y)

11. Where did the patient first seek medical advice?
- ☐ 1. government hospital
- ☐ 2. private hospital
- ☐ 3. private practitioner
- ☐ 4. Ayurvedic institution (public/private)
- ☐ 5. other (specify) .....

12. Was patient admitted to hospital?
- ☐ 1. yes → to Q. 13
- ☐ 2. no
- ☐ 3. not known

} skip to Q. 21

13. If yes, date of admission: ☐☐ ☐☐ ☐☐ (d d m m y y)

14. Name of hospital: .....

15. Ward: .....

16. BHT no: .....

17. Date of discharge/transfer or death: ☐☐ ☐☐ ☐☐ (d d m m y y)

18. If transferred, name of hospital .....

19. Was patient transferred from some other hospital?
☐ 1. yes ☐ 2. no

20. If "yes", where was the patient transferred from? .....

21. Outcome of the case
- ☐ 1. cured
- ☐ 3. transferred
- ☐ 2. died
- ☐ 4. not known

C. CLINICAL DATA

Case definition: acute illness including jaundice, dark urine, fever, anorexia, malaise, extreme fatigue, abdominal (right upper quadrant) tenderness with increasing upper limits of serum alanine aminotransferase & urine urobilinogen

22. Symptoms and signs
- ☐ 1. jaundice
- ☐ 2. loss of appetite
- ☐ 3. extreme fatigue/malaise
- ☐ 4. fever
- ☐ 5. dark urine
- ☐ 6. abdominal tenderness
- ☐ 7. other .....

23. Complications
- ☐ 1. encephalitis
- ☐ 2. liver failure
- ☐ 3. other .....

For office use only
Compatible with the case definition:
- ☐ Yes
- ☐ No

D. LABORATORY FINDINGS

24. Laboratory tests done: ☐ 1. yes ☐ 2. no ☐ 3. reports not available ☐ 4. unknown

25. If yes:

	Name of test	Date (dd/mm/yy)	Result
Biochemical	SGPT		
	SGOT		
	Serum bilirubin		
	Others (specify):		
Seromarkers	HBsAg		
	Others (specify):		

E. RISK FACTORS

26. Did the patient have a contact history of jaundice during the last 6 months?
☐ 1. yes ☐ 2. no ☐ 3. not known

27. If yes, where?
☐ 1. home
☐ 2. neighbourhood
☐ 3. school
☐ 4. working place
☐ 5. not known
☐ 6. other (specify)
.....

28. Has the patient shared razors or syringes with other people?
☐ 1. yes ☐ 2. no ☐ 3. not known

29. Does the patient have any tattoos?
☐ 1. yes ☐ 2. no ☐ 3. not known

30. Had the patient been administered any injections (including immunization or other parenteral interventions) during the last 6 months?
☐ 1. yes ☐ 2. no ☐ 3. not known

31. If 'yes', where?
☐ 1. hospital
☐ 2. private sector
☐ 3. other (specify):
.....
.....
.....

32. Has the patient had any surgical or dental intervention during the last 6 months?
☐ 1. yes
☐ 2. no
☐ 3. not known

33. If "yes", where?
☐ 1. hospital
☐ 2. private sector
☐ 3. not known
☐ 4. other (specify) .....

34. Specify the intervention: .....
.....
.....

F. PERSONAL AND DOMESTIC HYGIENE

35. Water supply
☐ 1. pipe
☐ 2. own well
☐ 3. common well
☐ 4. stream/ river
☐ 5. other (specify).....
☐ 6. not known

36. Type of drinking water
☐ 1. boiled
☐ 2. unboiled
☐ 3. other (specify).....
☐ 4. not known

37. Type of latrine
☐ 1. flush
☐ 2. water seal
☐ 3. pit
☐ 4. no latrine
☐ 5. other (specify).....
☐ 6. not known

G. VACCINATION STATUS

38. Has the patient received vaccination against hepatitis in the past? ☐ 1. yes ☐ 2. no ☐ 3. not known

39. If yes, type of vaccine:

		Date of immunization (dd/mm/yy)	Place of immunization*
☐ Hepatitis A			
☐ Hepatitis B	☐ 1st dose		
	☐ 2nd dose		
	☐ 3rd dose		

* MOH office / government hospital / PHM Field clinic / private hospital / clinic / GP / not known / other

H. FURTHER INFORMATION

40. Presence of risk factors (eg. alcohol and drug use, unsafe sex, family history of hepatitis, recent gathering/attending festivals, etc.)

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41. The most likely route(s) of transmission in this case as judged by the officer (more than one response is allowed):

☐ 1. water ☐ 2. food ☐ 3. person to person
☐ 4. parenteral ☐ 5. sexual ☐ 6. perinatal

42. Final diagnosis according to the records :
☐ 1. Hepatitis A
☐ 2. Hepatitis B
☐ 3. Hepatitis C
☐ 4. Other (Specify) .....
☐ 5. Not available

43. Lab confirmed :
☐ 1. yes ☐ 2. no
☐ 1. yes ☐ 2. no
☐ 1. yes ☐ 2. no
☐ 1. yes ☐ 2. no

44. Remarks: .....

Signature: ..... Name:.....

Date: ..... Designation: .....

Please return to:
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email: epidunit@sltnet.lk Tel: 011-2695112 / 2681548 Fax: 011-2696583