BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

BC Centre for Disease Control
Epidemiology Services
655 West 12th Avenue
Vancouver BC V5Z 4R4

Tel: (604) 707-2517
Fax: (604) 707-2516
epidinfo@bccdc.ca
www.bccdc.ca

Hepatitis A Follow-Up Form

Date Case Contacted (YYYY/MM/DD):	Form Completed By:	Email Address:
Attending Physician:	Phone # attending:	Discussed with attending: □ yes □ no If yes, date:
□ Lab results (HAV IgM) as attached or (specify): Date Collected (YYYY/MM/DD):		
This case is: □ Confirmed □ Clinical		

A. Demographic Information

Case Surname:	**First Name:**	**Initial:**
PHN:	Birth date (YYYY/MM/DD):	Age:
Gender: □ Male □ Female	Ethnicity:	
Parent/Guardian name (If Applicable):		
Address:	Phone # (Include Area Code): Cell #: Email:	
Type of residence: □ Private home □ Institution □ On Reserve		
Occupation: □ Food/drinking water handler □ Daycare worker □ Adult care facility or prison □ Hospital worker		
Place of work/address/phone #:		
Family Physician □ attending (details as above) Or if different from above: **Surname:** **First Name:** **Initial:** City: Phone # (Include Area Code):		

Case initials ________

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B. Case Details

Check (√) if applicable: If not (√) then = not present:

Symptoms:	Onset Date	Resolution Date
□ Jaundice		
□ Fever		
□ Abdominal Pain		
□ Vomiting		
□ Nausea		
□ Diarrhea		
□ Other:		

History of prior hepatitis A infection □ yes □ no If yes, Date (YYYY/MM/DD):

Prior immunization for hepatitis A □ yes □ no If yes, Date (YYYY/MM/DD):

** Calculate Infectious Period **

14 days prior to first symptom onset to 7 days after jaundice onset, or 14 days after first symptom, whichever is longer

From (YYYY/MM/DD): To (YYYY/MM/DD):

C. Exposure Information/Risk Factors

Exposure (incubation) Period: *(max 50 days to min 15 days prior to first symptom)*
From (YYYY/MM/DD): To (YYYY/MM/DD):

Check box if applicable. Indicate DNA, "did not ask", beside box if applicable

□ **Known contact of hepatitis A case**

Name of case: Telephone #:

Place of contact: Contact's physician name/telephone:

□ **Post exposure prophylaxis given** If yes, Date (YYYY/MM/DD):
Name and Lot # (if known): Vaccine: IgG:

□ **Travel/Immigration:**
□ Domestic □ International Dates/place/details of travel:

□ **Occupational Exposure:** Details:

□ **Raw or Cooked Shellfish:** Details:

□ **Child Daycare Attendee:** Specify:

□ **Suspect Food:** Specify:

□ **Suspect Water Supply:** Specify:

□ **Institutional Care:** Details:

The following questions are of a sensitive nature and should be asked if no alternative exposure is identified:

□ **High risk sexual activity (oral-anal sex):** Specify:

□ **Injection drug use:** Specify drug & if "rig"/needle shared:

□ **Other street drug use/indicate if shared:** Specify:

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Complete section below if no clear exposure identified:

Restaurants visited in past 2 months:

Name:	Date (YYYY/MM/DD):	Items eaten:

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D. Contact Information

Estimated Infectious Period: **see **Calculate Infectious Period** page 2**

From (YYYY/MM/DD): To (YYYY/MM/DD):

Name of Contact:	Relationship:	Age:	Sex:	Telephone #	Date of Contact (YYYY/MM/DD)	Symptoms?	Date Vaccine Given	Lot#
Household:								
Place of Work:								
Contacts for whom case has prepared food:								

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Name of Contact:	**Relationship:**	**Age:**	**Sex:**	**Telephone#**	**Date of Contact (YYYY/MM/DD)**	**Symptoms?**	**Date Vaccine Given**	**Lot#**
Child Day Care contacts:								
Additional/Other Contacts: *(sexual partners, share drugs/cigarettes, etc)*								

Please use additional pages if needed.

Case initials _______