



Confidential when completed

**PERSON REPORTING**

Health Authority:	<input type="checkbox"/> FHA	<input type="checkbox"/> IHA	<input type="checkbox"/> VIHA	<input type="checkbox"/> NHA	<input type="checkbox"/> VCH
Name:					
	<i>Last</i>		<i>First</i>		
Phone:	( )	-	ext.		
Email:					

Date Report Received at HU (YYYY/MM/DD): \_\_\_\_\_

Contact attempts (date and time)	Interview?
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>

Interviewer:  Not located

**A. CLIENT INFORMATION**

Name:			Alternate Name(s):		
<i>Last</i>	<i>First</i>	<i>Middle</i>			
PHN:	Date of Birth:	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
	YYYY / MM / DD				
Home Address:			City:		
<i>Unit #</i>	<i>Street #</i>	<i>Street Name</i>			
Postal code:	Province:	Phone number (home/office/cell)	( )	-	ext.
Email:	Physician Name		Physician Phone Number:		
	<i>Last</i>	<i>First</i>			
	Attending Physician Name (if applicable)		Attending Phone Number:		
	<i>Last</i>	<i>First</i>			
Interview conducted with:					

**B. ABORIGINAL INFORMATION**

Do you wish to self-identify as an Aboriginal Person?	<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> No	
	<input type="checkbox"/> Not asked	<input type="checkbox"/> Yes	
Aboriginal Identity:	<input type="checkbox"/> Asked, but unknown	<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> First Nations
<input type="checkbox"/> First Nations and Inuit	<input type="checkbox"/> First Nations and Métis	<input type="checkbox"/> First Nations, Inuit and Métis	<input type="checkbox"/> Inuit
<input type="checkbox"/> Inuit and Métis	<input type="checkbox"/> Métis	<input type="checkbox"/> Not asked	
First Nations Status:	<input type="checkbox"/> Asked, but unknown	<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> Non-Status Indian
	<input type="checkbox"/> Not Asked	<input type="checkbox"/> Status Indian	

**C. CLASSIFICATION**

Confirmed  Probable  Not a Case

**Confirmed case:**

Laboratory confirmation of infection in the absence of recent hepatitis A vaccination by detection of immunoglobulin M antibody to hepatitis A virus (anti-HAV IgM) †

**AND**

Acute illness with discrete onset of symptoms and jaundice, **OR**  
Acute illness with elevated serum aminotransferase levels, **OR**  
An epidemiologic link to a person with laboratory confirmed hepatitis A infection.

† If available, use IgM from BCCDC PHL to determine case status

**Probable case:**

Acute illness in a person who is epidemiologically linked to a confirmed case



**D. CLINICAL INFORMATION**

Date of onset of symptoms: \_\_\_\_\_ Date of onset of jaundice, if present: \_\_\_\_\_  
YYYY / MM / DD YYYY / MM / DD

**Signs and Symptoms**

Abdominal discomfort     Diarrhea     Nausea     Other: \_\_\_\_\_  
 Anorexia     Dark urine     Fatigue     Malaise  
 Jaundice     Fever     Vomiting     Pale stools

**Hospitalization**

Admitted to hospital:     Yes     No     DK    Hospital name: \_\_\_\_\_  
Admission date: \_\_\_\_\_ Discharge date: \_\_\_\_\_  
YYYY / MM / DD YYYY / MM / DD

**Outcome**

Death:     Yes     No     DK    If yes, death date: \_\_\_\_\_  
YYYY / MM / DD

**E. PREVIOUS INFECTION AND IMMUNIZATION**

History of prior hepatitis A infection:     Yes     No     DK    If yes, date: \_\_\_\_\_

Hepatitis A immunization prior to exposure period:     Yes, 1 dose     Yes, 2 dose     No     DK

If immunized, specify:

	Administered Date (if known) <small>YYYY/MM/DD</small>	Documentation
Dose 1		<input type="checkbox"/> Documented, specify source: _____ <input type="checkbox"/> Undocumented
Dose 2		<input type="checkbox"/> Documented, specify source: _____ <input type="checkbox"/> Undocumented

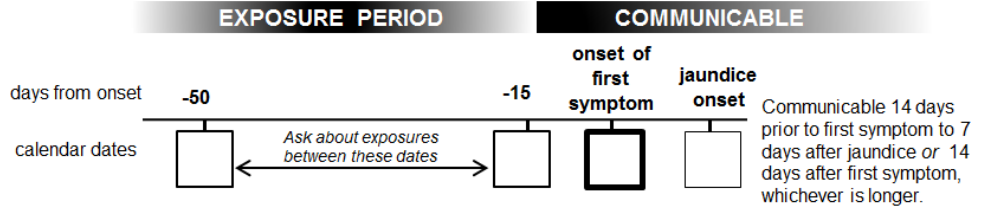
**F. LABORATORY INFORMATION**

Specimen type	Reporting lab	Collection date <small>YYYY / MM / DD</small>	Lab test	Result	Result description
			<input type="checkbox"/> Anti-HAV IgM <input type="checkbox"/> Anti-HAV Total <input type="checkbox"/> AST <input type="checkbox"/> ALT	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Equivocal <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Equivocal <input type="checkbox"/> Normal <input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Elevated	
			<input type="checkbox"/> Anti-HAV IgM <input type="checkbox"/> Anti-HAV Total <input type="checkbox"/> AST <input type="checkbox"/> ALT	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Equivocal <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Equivocal <input type="checkbox"/> Normal <input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Elevated	
			<input type="checkbox"/> Anti-HAV IgM <input type="checkbox"/> Anti-HAV Total <input type="checkbox"/> AST <input type="checkbox"/> ALT	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Equivocal <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Equivocal <input type="checkbox"/> Normal <input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Elevated	



**G. RISK FACTORS AND EXPOSURE INFORMATION**

Enter onset date of first symptom in heavy box. Count back to figure the probable exposure period.



**Contact with HAV case during exposure period**

Contact with another case\* of hepatitis A:  Yes  No  DK If yes, was other case\* a confirmed case (see section c):  Yes  No  DK

Name of other case\*: \_\_\_\_\_ Place of contact: \_\_\_\_\_

Other case\* telephone: \_\_\_\_\_

\*A symptomatic individual or confirmed hepatitis A case who was in contact with the client under investigation in the 15 to 50 days prior to onset

**Travel**

Travel or immigration during exposure period:  Yes  No  DK If yes:  within BC  outside BC but within Canada  outside Canada

Dates: DEPARTURE	Dates: RETURN	Locations (e.g., city, country, resort)	Hotel or residence	Foods brought back
YYYY / MM / DD	YYYY / MM / DD			

Travel organization or travelling partners: \_\_\_\_\_

Was travel or immigration the most likely source of infection<sup>†</sup>?  Yes

<sup>†</sup> Exposure (travel or immigration) to endemic area during entire exposure period **OR** Exposure (travel or immigration) to endemic area during a portion of their exposure period **AND** no epidemiological link to a confirmed HAV case or outbreak in BC. Hepatitis A endemic areas: South and Central America and Caribbean (including Mexico), Asia (excluding Japan), Africa, Middle East, Eastern Europe.

For cases who spent **any time** in the 15 to 50 days prior to onset in Canada and/or US, continue with remaining questions in Section G. For other cases, skip to Section H.

**Special Diet - Complete for Canada and US exposures only**

Vegetarian?  Yes  No  DK Food allergies / avoidances / special diet?  Yes  No  DK

If yes, details: \_\_\_\_\_

**Food Exposures – Complete for Canada and US exposures only**

In the 15 to 50 days prior to onset did you eat...	Response	Details (e.g., where consumed, type, brand)
Frozen pomegranate seeds/arils	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Frozen strawberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Frozen blackberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Frozen raspberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Frozen blueberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Any other frozen berries or frozen fruit, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Mussels (raw or cooked)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Scallops (raw or cooked)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Oysters (raw or cooked)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Shrimps/prawns (raw or cooked)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Any other raw or cooked shellfish, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Semi-dried tomatoes (e.g., sun-dried tomatoes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	



**G. RISK FACTORS AND EXPOSURE INFORMATION *continued***

Events, restaurants, and grocery stores visited in the 15 to 50 days prior to onset - *Complete for Canada and US exposures only*

Event/Social gathering	Location	Date (YYYY/MM/DD)	Foods Eaten
Restaurants (including: take-out, cafeteria, bakery, deli, kiosk)	Location	Date (YYYY/MM/DD)	Foods Eaten
Grocery stores for food consumed during the incubation period	Location	Foods Purchased	Brands/Other details

Other Exposures - *Complete for Canada and US exposures only*

In the 15 to 50 days prior to onset did/were you...	Response	Details (e.g., location, frequency)
Receive blood/blood product, tissue or organ? <sup>^</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Donate blood/blood product, tissue or organ? <sup>^</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Have contact with daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
In institutional care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Homeless or underhoused?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	

The following questions are of a sensitive nature. Ask as appropriate based on age and maturity level.

People who use drugs are at a higher risk for acquiring HAV infection. Do you currently use illicit drugs (injection or non-injection)?

Yes    No    DK    Unanswered

Hepatitis A virus can be transmitted sexually. Are you currently sexually active?

Yes    No (if no, skip to next section)    DK    Unanswered

Hepatitis A virus can be transmitted through oral-anal sexual contact.<sup>1</sup> Is this a possibility in your case in the 15 to 50 days prior to onset?

Yes    No    DK    Unanswered

<sup>1</sup> Oral-anal sexual contact is defined as contact between the mouth, lips or tongue of one person and the anal or perianal area of another person. It can also include oral contact with sexual toys or other body parts (e.g. penis, finger) which had prior contact with the anal area, rectum or feces. Some people refer to oral-anal sex as rimming and to manual-oral sex as fingering or fisting.

<sup>^</sup> Inform BCCDC of potential transfusion transmissible infections (i.e. case has received or donated blood/blood product, tissue or organ(s) 15 to 50 days prior to onset) so that BCCDC can inform Canadian Blood Services or BC Transplant. For those using Panorama please also create an acquisition event (received) or transmission event (donated) in Panorama. See Section L.





## L. PANORAMA DATA ENTRY DETAILS

Record **contact with a known case** in >Investigation >> Investigation Details >>> Links & Attachments >>>> Hepatitis A Investigation form.

If **contact with a known case** = Yes, create an Acquisition Event on the Exposure Summary Screen (under Investigation on the left hand navigation).

Exposure Name: XXX-Contact-HepA *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, or NHA)*

Potential Mode of Acquisition: *Select most appropriate option*

Acquisition Start: date of first contact or 50 days prior to onset of symptoms (*select most recent*)

Acquisition End: most recent contact (*if known*)

Exposure Location: *enter place of contact details if known*

### Donation/receipt of blood, organs, or tissue

To report a **transfusion transmissible infection** for a case who has **received** blood, tissue or organ(s), create an Acquisition Event on the Exposure Summary screen (under Investigation on the left hand navigation) using the Acquisition Event Details screen.

*For blood:*

Exposure Name: XXX-TTI-HepA *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, or NHA)*

Potential Mode of Acquisition: Transfusion transmitted

Nature of Exposure: Received other blood/blood products

Exposure Start: Date of transfusion (*if exact date unknown, enter best estimate and select the "Estimated" flag*)

Exposure Location Name: *same as Exposure Name*

Exposure Setting Type: Facility – non-recreational

Exposure Setting: Hospital

Address: Details for facility where transfusion occurred

*For tissue or organs:*

Exposure Name: XXX-TTI-HepA *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, or NHA)*

Source description: Tissues/Organs

Potential Mode of Acquisition: Other

Nature of Exposure: *leave blank*

Exposure Start: Date of operation (*if exact date unknown, enter best estimate and select the "Estimated" flag*)

Exposure Location Name: *same as Exposure Name*

Exposure Setting Type: Facility – non-recreational

Exposure Setting: Hospital

Address: Details for facility where operation occurred

To report a **transfusion transmissible infection** for a case who has **donated** blood, tissue or organ(s), create a Transmission Event on the Exposure Summary screen (under Investigation on the left hand navigation) using the Transmission Event Details screen.

*For blood:*

Exposure Name: XXX-TTI-HepA *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, or NHA)*

Mode of Transmission: Transfusion transmitted

Nature of Transmission: Donated blood/blood products

Exposure Start: Date donated blood (*if exact date unknown, enter best estimate and select the "Estimated" flag*)

Exposure Location Name: *same as Exposure Name*

Exposure Setting Type: Facility – non-recreational

Exposure Setting: Canadian Blood Services

Address: Details for facility where blood was donated

*For tissue or organs:*

Exposure Name: XXX-TTI-HepA *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, or NHA)*

Source description: Tissues/Organs

Mode of Transmission: Other

Nature of Transmission: *leave blank*

Exposure Start: Date of operation (*if exact date unknown, enter best estimate and select the "Estimated" flag*)

Exposure Location Name: *same as Exposure Name*

Exposure Setting Type: Facility – non-recreational

Exposure Setting: Hospital

Address: Details for facility where operation occurred

Training Materials (<https://phsa.sp.gov.bc.ca/sites/PPHIS>): [Exposures – Reference Guide - Investigations](#)

System Guidelines (<https://phsa.sp.gov.bc.ca/sites/PPHIS>): [Documentation of Transfusion Transmissible Infections \(TTI\) in Panorama, Exposures – Reference Guide - Investigations](#)



**APPENDIX. Optional Contact Charting Form**

<b>Estimated Infectious Period:</b> see <b>**Calculate Infectious Period**</b> page 3										
From (YYYY/MM/DD):					To (YYYY/MM/DD):					
Identifier	Name of Contact	Relationship	Age	Sex	Telephone #	Date of Contact (YYYY/MM/DD)	Symptoms?	Date Biologics Given (specify vaccine or Ig)	Lot#	Excluded?
<b>Household:</b>										
<b>Place of Work:</b>										
<b>Contacts for whom case has prepared food:</b>										



**APPENDIX. Optional Contact Charting Form – continued**

Identifier	Name of Contact	Relationship	Age	Sex	Telephone #	Date of Contact (YYYY/MM/DD)	Symptoms?	Date Biologics Given (specify vaccine or Ig)	Lot#	Excluded?
<b>Child Day Care contacts:</b>										
<b>Additional/Other Contacts:</b> <i>(sexual partners, share drugs/ cigarettes, etc.)</i>										

Please use additional pages if needed.