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| **ACUTE HEPATITIS OF UNKNOWN AETIOLOGY INVESTIGATION FORM** |
| *This form should be completed in full for each suspected acute hepatitis of unknown aetiology case/contact**Ideally* ***the attending clinician*** *should complete the form* |
| **PERSON COMPLETING THE FORM\*** \*This form should be filled out by attending clinician (Doctor) for each suspected case |
| **Name** |  | **Surname** |  |
| **Contact number** |  | **Date of reporting** |  |
| **Healthcare Facility**  |  |
| **Designation** | Attending Dr ⎕ | Specify other |
| **SOURCE(S) OF INFORMATION** |
| **Interview** | Yes ⎕ No ⎕ | **Medical record review** | Yes ⎕ No ⎕ |
| **Person(s) interviewed** | Clinician⎕ | Patient⎕ | Caregiver⎕ | Parent⎕ | Guardian ⎕ | Contact/Epi linked case⎕ | Other⎕ |
| **CASE/PATIENT DEMOGRAPHIC DETAILS** |
| **Name** |  | **Surname** |  | **Date of birth** |  |
| **Age** (years) |  | **Sex** (M/F) |  | **Contact number** |  |
| **Race** | Black⎕ | Indian⎕ | Coloured⎕ | White⎕ | Other⎕ | Specify other |
| **Residential address** |  |
|  |
| **District** |  | **Province** |  |
| **Is the person a learner, at crèche and/or going for childcare outside of the home?** | Yes ⎕ No ⎕ |
| **If so, provide name of school, crèche and/or location of childcare** |  | **Grade** |  |
| **Do any household members work outside of the home? (Y/N)** |  |
| **If yes, state where**  |  |
| **CLINICAL DETAILS** |
| **Date of onset of symptoms** |  |
| **Date of first visit to health care provider for investigation of symptoms** |  |
| **Tick all the listed symptoms below that the person experienced:** |
| Fever⎕ | Diarrhoea⎕ | Fatigue⎕ | Pale stools⎕ | Jaundice⎕ |
| Dark Urine⎕ | Nausea⎕ | Vomiting⎕ | Abdominal pain⎕ |
| Other⎕ | **If other, specify** |  |
| **Did the person experience any complications? (Y/N)** |  |
| **If complications were experienced, tick all the listed complications below that the person experienced:** |
| Bleeding⎕  | Date: | Liver failure⎕ | Date: |  | Other⎕ |
| If bleeding, which sites |  | If bleeding, give laboratory indices (if done) | INR:PTT: | D-dimers: |
| **If other, specify** |  |
| **List any comorbidities** |  |
| **Has the child had a blood transfusion in the last months? (Y/N)** |  |
| **Has the child been diagnosed with COVID-19 in the last 6 months? (Y/N)****If yes, please provide the date of the first positive test** |  |
| **Has the child consulted any other services for their health in the last 3 months (e.g. traditional healer?) (Y/N)** |  |
| **Has the child used any medication (including traditional/herbal) prior to presentation? (Y/N) If yes, please specify**  |  |
| **Has the child been exposed to any toxic chemicals prior to presentation (Y/N)?** **If yes, please specify**  |  |
| **ADMISSION DETAILS** |
| **Admitted? (Y/N)** |  | **Previous admissions in the last 12 months? (Y/N)** |  | **Number of previous admissions** |  |
| **Name of health facilities previously admitted to** |  |
| **Previous admission diagnoses**  |  |
| **Date of current admission** |  | **Health facility name (district & province)** |  |
| **Ward** |  | **Outcome** | Died⎕ | Discharged⎕ | Unknown / refusal of hospital treatment⎕  |
| **Admission/facility record number** |  | **Outcome date** |  |
| **TREATMENT INFORMATION** |
| **Is the child on antimicrobial and/or antiviral therapy? (Y/N)** |  | **Number of antimicrobials and/or antivirals** |  |
| **Name of antimicrobial and/or antiviral** | **Daily dose (mg)** | **Date start** | **Date stopped** | **Name of antimicrobial** **and/or antiviral** | **Daily dose (mg)** | **Date start** | **Date stopped** |
| **1.** |  |  |  | **6.** |  |  |  |
| **2.** |  |  |  | **7.** |  |  |  |
| **3.** |  |  |  | **8.** |  |  |  |
| **4.** |  |  |  | **9.** |  |  |  |
| **5.** |  |  |  | **10.** |  |  |  |
| **EXPOSURE RISK DETAILS** |
| **Does the patient have a family history of the following conditions?** | Liver disease ⎕ | Autoimmune disease⎕ |
| **Has the patient had close contact with anyone with the following viral infections?**Specify other | Hepatitis A ⎕  | Hepatitis B+/- D⎕ |  Hepatitis C ⎕ |  Hepatitis D ⎕ |
| Rubella⎕ | Enterovirus ⎕ | CMV ⎕ | EBV⎕  | HSV⎕ |
| Varicella Zoster ⎕ | Parvovirus ⎕ | Hepatitis of unexplained origin ⎕ | Other ⎕ |
| Specify other |
| **Has the child had contact with person(s) with similar symptoms or illness? (Y/N)** |
| **If yes, provide details of the symptomatic or ill person(s), including contact details:** |
| *Include name, address, contact details* |
|  |
| **Has the child attended any gatherings within 90 days prior to onset of illness? (Y/N)** |
| **If yes, provide details:** |
| **Name of event:** | **Location:** | **Date of event:** |
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| ***Travel History***  |
| **Has the child travelled *outside* the borders of South Africa within 90 days prior to onset of illness? (Y/N)** |  |
| **If yes, specify country/countries visited** |  |
| **Date of departure from South Africa** |  | **Date of return to South Africa** |  |
| **Has the child travelled *within* the borders of South Africa within 90 days prior to onset of illness? (Y/N)** |  |
| **If yes, specify area(s) visited below:** |
| **Place visited:** | **Date of arrival:** | **Date of departure:** |
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| ***Food and Water*** |
| **Is there safe water available for use in the home from internal taps? (Y/N)**  |  |
| **Does the patient’s home use communal taps/water tankers? (Y/N)** |  |
| **Does the patient’s home treat their water before drinking it? (Y/N)****If yes, indicate how (Boil/Chemical/Bleach/Chlorine tablet/Other)** |  |
| **Has there been any temporary lack of safe water in the patient’s home or at any other location the child spends time at? (Y/N)****If yes, please provide details** |  |
| **Has the child been exposed to open water sources e.g. rivers, streams? (Y/N)****If yes, please provide details** |  |
| **Was the child suspected of being part of a common-source foodborne or waterborne outbreak? (Y/N)** **If yes, please provide details** |  |
| **Does the child have the same diet as the rest of the household? (Y/N)****If no, please specify differences** |  |
| ***Vaccines*** |
| **Has the child (if 12 years or older) been vaccinated against COVID-19? (Y/N)**  |  |
| Date |  | Vaccine type |  |
| Date |  | Vaccine type |  |
| Date |  | Vaccine type |  |
| **Has the child been vaccinated against viral hepatitis? (Y/N)****If yes, please specify against which viral hepatitis**  |  |
| Hep A vaccine |  | Date |  | Date |  |
| Hep B vaccine |  | Date |  | Date |  |
| **Are the child’s vaccinations up to date according to the RTHC (Y/N)** |  | Age of last vaccination (months) |  |
| **LABORATORY INFORMATION \*****\***Please list all tests that have been submitted even if results are not available yetPlease don’t list tests that have not been ordered |
| **Were specimens collected from this child for laboratory testing? (Y/N)** |  |
| **Test conducted** | **Testing Laboratory** | **Specimen type** | **Date of collection** | **Lab reference number** | **Test Result** |
| Hepatitis A |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |
| Hepatitis C |  |  |  |  |  |
| Hepatitis D |  |  |  |  |  |
| Hepatitis E |  |  |  |  |  |
| CMV |  |  |  |  |  |
| HSV |  |  |  |  |  |
| COVID PCR |  |  |  |  |  |
| COVID antibody |  |  |  |  |  |
| Serum paracetamol levels |  |  |  |  |  |
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| **DATA CAPTURE INFORMATION** |
| **Data capture date** |  | **Data capturer name** |  | **Line-list record number** |  |