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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** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 yet  Please 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** | | | | | | | | | | | |  | |