State of California—Health and Human Services Agency

Department of Public Health
Surveillance and Statistics Section
P.O. Box 997377, MS 7306
Sacramento, CA 95899-7306

TRANSFUSION ASSOCIATED HEPATITIS CASE RECORD

Patient last name	first name	middle initial	Date of birth (mm/dd/yy)	Age	Sex
			____/____/____		☐ Female ☐ Male

Address (number, street)	City	State	County	ZIP code

Telephone number	Social security number
Home ( ) Work ( )	

Type of work	Employer (name of company or institution)

If female, was patient pregnant at the time of onset? ☐ Yes ☐ No ☐ Unknown

CLINICAL INFORMATION

Date of first symptoms (mm/dd/yy)	Did patient have jaundice?	Did patient die?	If yes, date of death (mm/dd/yy)
____ /____ /____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No	____ /____ /____

Reporting physician's diagnosis	Telephone number
	( )

Was patient hospitalized for this illness?	Admit date (mm/dd/yy)	Discharge date (mm/dd/yy)	Hospital name	City
☐ Yes ☐ No	____ /____ /____	____ /____ /____		

Did patient receive blood, blood products, or tissue graft during the SIX months before onset?

☐ Yes ☐ No ☐ Unknown If yes, please complete supplemental sheet on the back.

Was patient a blood donor during the SIX months before onset?

☐ Yes ☐ No ☐ Unknown If yes, please provide name of blood bank or agency and date(s):

Blood bank/agency	Date(s)

Did patient have self-injection of habituating drugs (narcotics, barbiturates, amphetamines, etc.) in last SIX months?

☐ Admitted by patient ☐ Not admitted, but suspected from other information ☐ No

Did patient have personal contacts with jaundice case during SIX months before onset?	Did patient have tattooing within last SIX months?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Additional information on manner in which patient may have acquired infection—please explain:

LABORATORY TEST RESULT

Test(s) done:						
	Hepatitis A	Anti-HAV Igm	☐ Positive	☐ Negative	☐ Not done	☐ Unknown
	Hepatitis B	HBsAg	☐ Positive	☐ Negative	☐ Not done	☐ Unknown
	Hepatitis C	Anti-HCV	☐ Positive	☐ Negative	☐ Not done	☐ Unknown

PROBABLE SOURCE

☐ Blood or blood products ☐ Drug injection ☐ Sexually transmitted ☐ Other, specify: _____

Remarks

Person completing form (please print)	Telephone number	Date

Agency name

TRANSFUSION CASE RECORD SUPPLEMENTAL DATA

Patient's (Blood Recipient) Information

Last name	first name	middle initial	Date of birth (mm/dd/yy)	Social security number
			_____ / _____ / _____	

Date of first hepatitis symptoms	Hospital name
_____ / _____ / _____	

LIST ALL TRANSFUSIONS OF BLOOD, BLOOD COMPONENTS, AND PRODUCTS GIVEN ANY TIME IN SIX MONTHS BEFORE ONSET OF HEPATITIS
(If additional space is needed, please make a copy as a continuation and staple together.)

No.	Blood Product Given*	Unit Number	Date Given to Patient (mm/dd/yy)	Blood Bank (at which blood donor was bed)	Date of Donation (mm/dd/yy)	Donor's Name	Birth Date (mm/dd/yy)	Social Security Number	Address/ZIP Code	Subsequent Testing Date (mm/dd/yy)
1										
2										
3										
4										
5										
6										
7										
8										

Remarks *(If necessary, please make copy for additional information.)*

*Includes whole blood, packed red cells, platelets, single donor plasma, frozen red blood cells, fresh frozen plasma, and pooled plasma.

Person completing form (if different from front page)	Date	Telephone number
		( )

Agency name