



Enhanced Hepatitis C Case Investigation Form

Instructions:

Healthcare professionals (HCPs) have a legislative duty to report notifiable and reportable diseases to the Chief Public Health Officer (CPHO) as required in the [NWT Public Health Act](#) (2009, SNWT 2007, c.17, SI-007-2009), with required information and timelines for reporting as defined in the [Disease Surveillance Regulations](#) (2009, R-096-2009). This information is used for territorial and national surveillance and informs public health planning and interventions. This reporting by the HCPs is accomplished by submitting this form to the Office of the Chief Public Health Officer (OCPHO). Information on cases of the following diseases is reportable within specific time frames:

	Timeline for submitting <i>Case Investigation Form</i> to OCPHO after making a diagnosis or opinion	Sections of <i>Case Investigation Form</i> to complete
Hepatitis C	24 hours	All (Sections 1-7) and contact tracing form (Section 8)

In addition to case information, HCPs shall make reasonable efforts to initiate contact tracing within 24 hours of a reportable disease diagnosis and provide the OCPHO with information respecting the contact tracing and specific control measures that have been initiated or are being carried out, as outlined the [Reportable Disease Control Regulations](#) (R-128-2009).

What to Report

Hepatitis C

- For Part 2 written report within 24 hours:
 - Confirmed and probable cases are to be reported to the Office of the Chief Public Health Office (OCPHO) within **24 hours** after diagnosis is made or opinion is formed by completing the Enhanced Hepatitis C Case Investigation Form then submitting to Communicable Disease Control Unit (CDCU) via secure medical fax 867-873-0442 or Secure File Transfer CDCU@gov.nt.ca.
 - If there are any updates regarding the case or contacts the appropriate form will need to be resent with the additional information
 - **Immediately** report all outbreaks or suspect outbreaks by telephone (867)-920-8646 to the OCPHO

Contact information

- Who to identify as a contact and the advice given will vary for the reportable disease as outlined in the respective [Communicable Disease Manual](#) chapter.

Important!

An enhanced hepatitis C case investigation and contact tracing form, even if not fully complete, must still be reported (submitted) to the OCPHO within the timeframes identified above. It is expected that HCPs submit an *updated* investigation and contact tracing form as new information is received.

Completed report forms (initial forms and updates) should be sent to OCPHO by
Medical Confidential Fax: 867-873-0442 or
Secure File Transfer: CDCU@gov.nt.ca



Enhanced Hepatitis C Case Investigation Form

Report is: <input type="checkbox"/> Initial <input type="checkbox"/> Update New information provided on section(s):			
SECTION 1: CASE INFORMATION			
Affix Label	Last Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Not Asked
	First Name:		Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex
	Date of Birth (YY/MM/DD):		Home Community:
	HCN (including OOT HCN):		Province/Territory:
	Consent to: <input type="checkbox"/> leave voicemail messages - <input type="checkbox"/> cell and/or <input type="checkbox"/> home phone <input type="checkbox"/> send text messages		
	Phone #(s):		
SECTION 2: CLASSIFICATION/DISEASE REPORTING			
Classification: <input type="checkbox"/> Confirmed		Stage: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Resolved <input type="checkbox"/> Perinatally acquired <input type="checkbox"/> Unspecified	
Prior Hepatitis C diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Region of diagnosis (P/T/Country) _____			
Date of diagnosis ____/____/____ (YY/MM/DD) Was the case treated for Hepatitis C? _____			
SECTION 3: SIGNS & SYMPTOMS			
<input type="checkbox"/> Asymptomatic or <input type="checkbox"/> Earliest Onset Date: ____/____/____ (YY/MM/DD)			
Check all that apply:			
Abdominal pain	Onset date: ____/____/____	Fever	Onset date: ____/____/____
Anorexia	Onset date: ____/____/____	Jaundice	Onset date: ____/____/____
Arthralgia/joint pain	Onset date: ____/____/____	Malaise/fatigue	Onset date: ____/____/____
Clay coloured stools	Onset date: ____/____/____	Nausea/vomiting	Onset date: ____/____/____
Dark urine	Onset date: ____/____/____	Other:	Onset date: ____/____/____
SECTION 4: REASON FOR TESTING			
<input type="checkbox"/> Routine Screening <input type="checkbox"/> Contact of a Case <input type="checkbox"/> Risk Factor(s) <input type="checkbox"/> Symptomatic <input type="checkbox"/> Prenatal <input type="checkbox"/> Other, specify: _____			
SECTION 5: LABORATORY INFORMATION			
<input type="checkbox"/> Negative anti-HCV within the past 12 months if so DATE: ____/____/____ (YY/MM/DD)			
<input type="checkbox"/> Negative HCV RNA within the past 12 months if so DATE: ____/____/____ (YY/MM/DD)			
Specimen collection date for current investigation: ____/____/____ (YY/MM/DD)			
<input type="checkbox"/> anti-HCV, Result: _____		<input type="checkbox"/> HCV RNA, Result: _____ <input type="checkbox"/> HCV Ag, Result: _____	
<input type="checkbox"/> anti-HAV IgM, Result: _____		<input type="checkbox"/> anti-HBc IgM, Result: _____	



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SECTION 6: POSSIBLE RISK BEHAVIOUR					
Please complete the following:	Yes	No	Un-known	Declined to Answer	Not Asked
BLOOD/TISSUE/ORGAN DONATION Is the case a recipient of a blood/blood product, tissue, or organ transplant prior to 1992 <u>within Canada</u> ? Is the case a recipient of a blood/blood product, tissue, or organ transplant <u>outside of Canada</u> ? Does the case have a history of donating blood, tissue, or organ(s)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
IMMIGRATION AND TRAVEL Was the case born in, travelled to, or lived in a region with high prevalence of hepatitis C, such as: Central, East and South Asia, Eastern Europe, North Africa and the Middle East, Sub-Saharan Africa, or Australia and Oceania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BEHAVIOURAL Does the case inject drugs or have <u>any</u> history of injection drug use (IDU)? Has the case shared injection, intranasal, or inhalation drug use equipment, <u>even once</u> ?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
SEXUAL/BLOOD-BORNE INFECTIONS Was the case a sexual contact of a known case of hepatitis C or person at high risk of hepatitis C infection (e.g., history of IDU)? Does the case have any other STBBIs or a history of STBBI infection (e.g., HIV, syphilis, etc.)?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
HOUSEHOLD CONTACT Does the case live in the same household as a known case of hepatitis C? If yes, does the case share personal care items, such as nail clippers, toothbrushes or razers with the known case?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
PERCUTANEOUS EXPOSURE Has the case ever had acupuncture, or did they get any tattoos or piercings, or scarification? Has the case ever had a non-occupational needle stick injury?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
MEDICAL EXPOSURE In any country where infection prevention control practices are not standardized, did the case have an invasive medical or dental procedure (e.g., dialysis, cosmetic surgery, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCCUPATIONAL EXPOSURE Has the case had an occupational needlestick injury? Has the case had any occupational exposure to blood or body fluids?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
PREGNANCY Is the case pregnant? Was the case born to a mother with hepatitis C infection?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
INCARCERATION Is the case currently incarcerated or were they incarcerated in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):					
SECTION 7: REPORTING					
Clinic Site or Hospital Unit:					
Completed by:	Signature:				
Phone:	Date:				
Comments:					

How to submit: By Medical Confidential Fax: 867-873-0442 OR Secure File Transfer: to CDU@gov.nt.ca



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CASE DEFINITIONS

Acute or recent infection

- Detection of hepatitis C virus RNA (HCV RNA) **or** detection of hepatitis C virus antigen (HCV Ag)
and
Clinical hepatitis (jaundice **or** peak elevated total bilirubin levels in serum $\geq 50.0 \mu\text{mol/L}$ **or** peak elevated serum alanine aminotransferase [ALT] $>200 \text{ IU/L}$) **and** no other known cause for clinical hepatitis
and
Negative anti-hepatitis A virus IgM (anti-HAV IgM) **and** negative anti-hepatitis B core IgM (anti-HBc IgM)
- or**
- Detection of HCV RNA **or** HCV Ag in a person with a documented negative test within the preceding 12 months for hepatitis C virus antibodies (anti-HCV) **or** HCV RNA
- or**
- Detection of anti-HCV in a person with documented negative anti-HCV within the preceding 12 months

Chronic infection

- Does not meet criteria for "Confirmed case - Acute or recent infection"
- and**
- Detection of HCV RNA
or
- Detection of HCV Ag

Resolved infection

- Does not meet criteria for "Confirmed case - Acute or recent infection" or "Confirmed case - Chronic infection"
- and**
- Negative HCV RNA test result
- and**
- Detection of anti-HCV

Unspecified hepatitis C

- Does not meet criteria for "Confirmed case - Acute or recent infection" or "Confirmed case - Chronic infection" or "Confirmed case - Resolved infection"
- and**
- Detection of anti-HCV

Perinatal infection (for children whose suspected route of transmission is perinatal)

- Detection of HCV RNA
- or**
- Detection of anti-HCV at ≥ 18 months of age



Report is: Initial Update

Index Case HCN:

MUST PRINT: HEPATITIS C CONTACT TRACING REPORT FORM

Instructions: As per the [Reportable Disease Control Regulations](#) (R-128-2009), HCPs shall make reasonable attempts to initiate contact tracing within 24 hours of reportable disease diagnosis. Please submit initial available contact information with the case investigation form. HCPs are also to provide the OCPHO with information respecting the contact tracing and specific control measures that have been initiated or carried out. Please submit an updated contact tracing form whenever:

1. A new contact has been identified
2. A contact has been treated

SECTION 8: PUBLIC HEALTH FOLLOW-UP				
Contact Tracing				
Contact of a case of (check all that apply): <input type="checkbox"/> Hepatitis C				
Affix Label	Last Name:		LAST EXPOSURE TO CASE	
	First Name:		Date (dd/mmm/yyyy): _____	
	HCN:		Location (NWT community or out of territory): _____	
	Age:	Birthdate (dd/mmm/yyyy):	Relationship to case (check all that apply):	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to answer		<input type="checkbox"/> Sexual partner <input type="checkbox"/> Drug-use partner <input type="checkbox"/> Household	
	Current Address:		<input type="checkbox"/> Other	
	Confirmed Phone Number(s):			
<input type="checkbox"/> Health care professional will follow-up with contact OR				
<input type="checkbox"/> Contact information forwarded to _____ for follow up				
Follow up information				
Date contact notified (dd/mmm/yyyy): _____				
Notes:				
Attempt to notify contacts:				
	Date	To/From	Outcome	Investigators Initials
1.				
2.				
3.				
4.				
Report date (dd/mmm/yyyy):		Clinic name:		Community:
Report completed by (print):			Reported completed by (signature):	

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