

# Hepatitis E Testing

## Division of Viral Hepatitis, Centers for Disease Control and Prevention

Type of specimen: serum / plasma / stool / other (specify): \_\_\_\_\_

Date specimen collected: \_\_\_\_/\_\_\_\_/\_\_\_\_

### FOR CDC USE ONLY

HEMI ID#

\_\_\_\_\_

Date Specimen Received:

\_\_\_\_/\_\_\_\_/\_\_\_\_

### Requesting Physician/Healthcare Provider/Public Health Department Contact

Name of requesting physician/healthcare provider: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_ E-mail: \_\_\_\_\_@\_\_\_\_\_

Facility or practice name: \_\_\_\_\_

Public Health Department contacted? ☐ Yes ☐ No If Yes, date contacted: \_\_\_\_/\_\_\_\_/\_\_\_\_ Which state: \_\_\_\_\_

Name of person contacted at Public Health Department: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_ E-mail: \_\_\_\_\_@\_\_\_\_\_

### Patient Details

Local Unique Identifier: \_\_\_\_\_ Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_-\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ or age (if DOB not known): \_\_\_\_ (years) Sex: ☐ Male ☐ Female

If female, was she pregnant at onset of illness? ☐ Yes ☐ No If pregnant, week gestation \_\_\_\_\_

Ethnicity/race:

☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ South Asian ☐ East Asian ☐ Middle Eastern

☐ Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other (specify) \_\_\_\_\_

### Current Illness

Date of onset of illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signs and Symptoms:

☐ Yellow sclera ☐ Dark urine ☐ Hepatomegaly ☐ Altered consciousness ☐ Abdominal pain ☐ Diarrhea

☐ Fever ☐ Arthralgia ☐ Rash ☐ Other (specify) \_\_\_\_\_

Was Patient hospitalized? ☐ Yes ☐ No If Yes: duration of hospitalization? \_\_\_\_\_

Did Patient develop liver failure? ☐ Yes ☐ No

Did Patient die? ☐ Yes ☐ No If Yes: what was date of death? \_\_\_\_/\_\_\_\_/\_\_\_\_

If Yes: did Patient die from liver failure? ☐ Yes ☐ No

If No: what was the cause of death? \_\_\_\_\_

Has Patient ever received an organ/tissue transplant? ☐ Yes ☐ No ☐ Not known

If Yes: what organ/tissue? \_\_\_\_\_ Date of transplant: \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Date unknown

Is Patient on immunosuppressive therapy? ☐ Yes ☐ No ☐ Not known

If Yes: specify medications \_\_\_\_\_

During the **3 months** prior to illness, did Patient receive blood transfusion(s)? ☐ Yes ☐ No ☐ Not known

If Yes: dates of transfusion : \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_

During the **3 months** prior to illness, did Patient receive blood product(s)? ☐ Yes ☐ No ☐ Not known

If Yes: what product(s)? \_\_\_\_\_

dates received: \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_

### Travel History

During the **3 months** prior to illness, did Patient arrive in the USA as a refugee or immigrant? ☐ Yes ☐ No ☐ Not known

If Yes: Date of arrival in USA: \_\_\_\_/\_\_\_\_/\_\_\_\_

Port of embarkation: \_\_\_\_\_

Country of Birth: \_\_\_\_\_

Country of residence before arrival in USA: \_\_\_\_\_

(If refugee) Camp(s) or Settlement Area(s): \_\_\_\_\_

Corresponding arrival date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Skip the next 3 questions and go to **Occupation and Eating Habits**

During the **3 months** prior to illness, did Patient travel outside the USA?

☐ Yes ☐ No ☐ Not known

If Yes: complete the table below

Country (countries) visited	Visited friends and relatives?	Date of arrival at destination	Date of departure from destination
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	____/____/____	____/____/____
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	____/____/____	____/____/____

During the **3 months** prior to illness, did **Patient's household** travel outside the USA?

☐ Yes ☐ No ☐ Not known

If Yes: complete the table below

Relationship to Patient	Countries visited	Date of arrival at destination	Date of departure from destination
		____/____/____	____/____/____
		____/____/____	____/____/____

During the **3 months** prior to illness, did **visitors from outside the USA** stay with Patient?

☐ Yes ☐ No ☐ Not known

If Yes: complete the table below

Relationship to Patient	Country of origin	Date of arrival in USA	Date of departure from USA
		____/____/____	____/____/____
		____/____/____	____/____/____

### Occupation and Eating Habits

Patient's primary occupation: \_\_\_\_\_

During the **3 months** prior to illness, did Patient work on a farm?

☐ Yes ☐ No ☐ Not known

If Yes: did Patient work with ☐ Pigs ☐ Other animals (specify) \_\_\_\_\_

During the **3 months** prior to illness, did Patient eat raw [rare] meat or seafood?

☐ Yes ☐ No ☐ Not known

If Yes: was it ☐ Pork ☐ Pig liver ☐ Other (specify) \_\_\_\_\_

☐ Oysters ☐ Mussels ☐ Other shellfish (specify) \_\_\_\_\_

### Diagnostic Laboratory Tests

#### Previous hepatitis E tests, if done:

Anti-HEV IgM: ☐ Pos ☐ Neg

Date blood collected: \_\_\_\_/\_\_\_\_/\_\_\_\_

Anti-HEV IgG: ☐ Pos ☐ Neg

If unknown, date of test: \_\_\_\_/\_\_\_\_/\_\_\_\_

HEV RNA: ☐ Pos ☐ Neg

#### Other tests done in context of current illness:

Anti-HAV IgM: ☐ Pos ☐ Neg

HBsAg: ☐ Pos ☐ Neg

Anti-HCV IgG: ☐ Pos ☐ Neg

Anti-HDV IgM: ☐ Pos ☐ Neg

Anti-CMV IgM: ☐ Pos ☐ Neg

Anti-EBNA: ☐ Pos ☐ Neg

Anti-EBV VCA IgM ☐ Pos ☐ Neg

Anti-VZV IgM: ☐ Pos ☐ Neg

Anti-HSV IgM: ☐ Pos ☐ Neg

Anti-adenovirus IgM: ☐ Pos ☐ Neg

Anti-parvovirus IgM: ☐ Pos ☐ Neg

Anti-leptospira IgM: ☐ Pos ☐ Neg

Anti-HAV total: ☐ Pos ☐ Neg

Anti-HBc IgM: ☐ Pos ☐ Neg

HCV RNA: ☐ Pos ☐ Neg

Anti-HDV total: ☐ Pos ☐ Neg

Anti-CMV IgG: ☐ Pos ☐ Neg

Monospot/heterophile antibody: ☐ Pos ☐ Neg

Anti-EBV VCA IgG ☐ Pos ☐ Neg

Anti-VZV IgG: ☐ Pos ☐ Neg

Anti-HSV IgG: ☐ Pos ☐ Neg

Anti-adenovirus IgG: ☐ Pos ☐ Neg

Anti-parvovirus IgG: ☐ Pos ☐ Neg

Anti-leptospira IgG: ☐ Pos ☐ Neg

HBV DNA: ☐ Pos ☐ Neg

CMV DNA: ☐ Pos ☐ Neg

EBV DNA: ☐ Pos ☐ Neg

VZV DNA: ☐ Pos ☐ Neg

### Liver Function Tests

Most recent values known of:

ALT (SGPT) \_\_\_\_\_ U/L

AST (SGOT) \_\_\_\_\_ U/L

Bilirubin \_\_\_\_\_ mg/dL

Date of test:

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

If there is other information to provide that could assist in the interpretation of hepatitis E tests, please indicate below