

# Hepatitis A questionnaire

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| WANIDD ID: |  | WANIDD updated: |  |
| Date of interview: |  | Interviewer: |  |
| Person interviewed (if not case): |  | Interpreter used: | Yes  No |
| Sporadic case  Contact of a case 🡪 case name or WANIDD ID: \_\_\_\_\_\_\_\_\_\_  Outbreak case 🡪 outbreakname or ID: \_\_\_\_\_\_\_\_\_\_ | | | |
| Probable source: |  | | |

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| **ATTEMPTS TO CONTACT CASE** | | |
| **Date** | **Time** | **Comments** |
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**Privacy message:** The information you provide in this questionnaire is for the purpose of trying to prevent further cases of illness. We do this by trying to find out what is likely to have caused your illness and also by providing you with information to reduce the spread of illness to others. The data collected is kept confidential and identifying information will not be disclosed for any other purpose without your consent. You can access your information by contacting WA Health.

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| **SECTION 1: DEMOGRAPHIC DATA** | | | |
| First name: |  | Last name: |  |
| Date of birth: | / / | Age: |  |
| Sex: | Male  Female  Other 🡪 Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Street address: |  | Suburb: |  |
| Postcode: |  |
| Home Tel: |  | Work Tel: |  |
| Mobile: |  | Email: |  |
| Country of birth: |  | Language spoken at home: |  |
| Are [you/the case] of Aboriginal or Torres Strait Islander origin?  *(check all that apply)* | Yes, Aboriginal  Yes, Torres Strait Islander  No  Not stated | | |
| Occupation (*full-time or part-time work, voluntary activities*) / school / child care: | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child at home  Home duties  Child in child care/pre-school  Retired / pensioner Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unemployed | | |
| **High-risk group\***  Yes  No 🡪 **If yes, record additional details in Sections 8 where applicable**  (*\*Includes food handlers, healthcare workers, institutional residents, child care workers, children in child care*) | | |

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| **SECTION 2: LABORATORY INVESTIGATIONS** | | | | |
| Test | Collection date | Laboratory | Lab ID | Result |
| Serology  Tested  Not tested | / / |  |  | IgM detected  IgM not detected  IgG detected  IgG not detected |
| PCR (HAV RNA)  Tested  Not tested | / / |  |  | RNA detected  RNA not detected |
| Liver function tests  Tested  Not tested | / / |  |  | **ALT**: ALP:  AST: GGT:  Bilirubin: |
| Specimen referred to PathWest for typing: | Yes  🡪 date: / /  No  🡪 reason: | | | |

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| **SECTION 3: TREATING DOCTOR / HOSPITAL** | | | |
| Name of treating Dr: |  | Telephone |  |
| Facility name: |  | Consent given by Doctor to interview: | Yes  No |
| Did the case present to the hospital? | Yes 🡪 Date: / /  No | Name of hospital: |  |
| Was the case admitted to hospital? | Yes 🡪 Date: / /  No | Date of discharge: | / / |
| Case deceased: | Yes 🡪 Date: / /  No | | |
| **\*Obtain preliminary information from treating doctor on illness, vaccination history and risk exposures: sections 4 – 7.** | | | |

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| **SECTION 4: CLINICAL** | | | |
| Onset date of first symptom:  / / | Onset date of jaundice:  / / | | Duration:  days  ongoing |
| **Did [you/case] experience any of these following symptoms associated with the illness?** | | | |
| Fever:  Yes  No  DK | Diarrhoea:  Yes  No  DK | | Bloody stools:  Yes  No  DK |
| Abdo pain/discomfort:  Yes  No  DK | Nausea:  Yes  No  DK | | Vomiting:  Yes  No  DK |
| Anorexia (loss of appetite) / Weight loss:  Yes  No  DK | Lethargy / malaise:  Yes  No  DK | | Joint/Muscle pain:  Yes  No  DK |
| Jaundice:  Yes  No  DK | Dark urine:  Yes  No  DK | | Pale faeces:  Yes  No  DK |
| Other:  Yes  No  DK | If yes specify: | | |
| **History of illness** | | | |
| Do [you/the case] have any underlying conditions or medications that suppress the immune system? (e.g. pregnancy, diabetes, cancers, steroids, etc.) | | Yes  No  DK  If yes specify: | |

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| **SECTION 5: VACCINATION HISTORY** | | | |
| Received hep A vaccination previously | | Yes  No  Unknown  Yes, as post-exposure prophylaxis | |
| Dose 1 date: | / / | Validated by: | doctor  practice records  AIR |
| Dose 2 date: | / / | Validated by: | doctor  practice records  AIR |
| Dose 3 date: | / / | Validated by: | doctor  practice records  AIR |
| Have [you/the case] received immunoglobulin in the past 4 weeks? | | Yes 🡪 Date: / /  No  Unknown | |
| **NOTE:** A 2 dose vaccination schedule is given for monovalent HAV vaccines and for combination HAV and Typhoid vaccines.  A 3 dose schedule is given for combination HAV and HBV vaccines. | | | |

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| **SECTION 6: RISK FACTORS DURING EXPOSURE PERIOD** | | | | | | | | | | |
| **Exposure period (between 15 and 50 days prior to onset of illness):**  / / to / / | | | | | | | | | | |
| **TRAVEL EXPOSURES** | | | | | | | | | | |
| Overseas?  Yes  No  DK  Interstate?  Yes  No  DK  Within state?  Yes  No  DK | | | If yes, provide travel details:  *(if multiple places, specify arrival and departure dates for each location)*  Destination(s):  Type of accommodation:  Departure date:  Return date: | | | | | | | |
| *International travellers only:* Did the case spend their entire exposure period overseas?  Yes 🡪 **Skip to Section 8**  No  Unknown | | | | | | | | | | |
| **CONTACT EXPOSURES** | | | | | | | | | | |
| Did [you/the case] have household / close contact with anyone who had recently travelled?  Yes  No  Unknown *if yes* complete table below | | | | | | | | | |
| Name | | Relation to case | | | Places visited | Departure date | Return date | | Did the traveller have any symptoms similar to you? |
|  | |  | | |  |  |  | | No  Yes - if yes, approximate onset date: |
|  | |  | | |  |  |  | | No  Yes - if yes, approximate onset date: |
| Did [you/the case] have household / close contact with a person known to have hepatitis A or similar illness (gastroenteritis)?  Yes  No  Unknown *if yes* complete table below | | | | | | | | | |
| Name | Relation to case | | | Phone contact | | Type/place of contact | | Illness onset/description | |
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| **CONTACT EXPOSURES** | | | | |
| Did [you/the case] have contact with a child under 5 years old?  Yes  No  Unknown *if yes* complete table below | | | | |
| Name | Relation to case | Phone contact | Type/place of contact | Name of child care/preschool (if applicable) |
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| **SECTION 7: SUPPLEMENTARY RISK FACTORS DURING EXPOSURE PERIOD – Non-food exposures** | | | |
| **Exposure period (between 15 and 50 days prior to onset of illness):**  \_\_\_\_/\_\_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_\_\_/\_\_\_\_ | | | |
| **NOTE: \* Both doctors and cases should be asked these questions; # only for cases 18 years and over** | | | |
| Exposure to untreated sewage  (e.g. sewage worker)? | Yes 🡪  No  Unknown | Specify the location(s) and details of exposure |  |
| **\***An inpatient in hospital? | Yes 🡪  No  Unknown | Specify the facility and dates admitted |  |
| **\***Received a transfusion of blood products? | Yes 🡪  No  Unknown | Specify the facility and date of transfusion |  |
| **# \***Marijuana use? | Yes 🡪  No  Unknown | Do you share drugs or equipment? | Yes  No  Unknown |
| Details of regular contacts: |  |
| Reported by: | Doctor  Case  Other: |
| **# \***Injecting drug use? | Yes 🡪  No  Unknown | Do you share drugs or equipment? | Yes  No  Unknown |
| Details of regular contacts: |  |
| Reported by: | Doctor  Case  Other: |
| **# \***Any sexual contact? | Yes 🡪  No  Unknown | Gender of the person | Male  Female  Unknown |
| Relationship of person to case | Regular partner  Casual partner  Sex worker  Client (case is a sex worker) |
| Did any sexual partners report similar symptoms prior to your encounter | Yes 🡪 approximate onset date:  No |
| Reported by: | Doctor  Case  Other: |
| Association with a correctional facility or remand centre? | Yes 🡪  No  Unknown | Specify location(s) and circumstances (e.g. visitor, staff, resident) |  |
| Drink any untreated water  (e.g. tank, surface water, bore, other)? | Yes 🡪  No  Unknown | Specify details of exposure and location(s) |  |

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| **SECTION 7b: SUPPLEMENTARY RISK FACTORS DURING EXPOSURE PERIOD – Food exposures** | |
| **I would like to ask you some questions relating to the foods you ate during the period of time before you became unwell. This time period is:** | |
| **Exposure period (between 15 and 50 days prior to onset of illness):**  \_\_\_\_/\_\_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_\_\_/\_\_\_\_ | |
| **As this is a long period of time you may like to get a calendar or diary to help you remember what foods you may have been eating at this time.** | |
| **During this period did you purchase your groceries from:** | **Where** (location) |
| **Aldi** |  |
| **Coles** |  |
| **IGA** |  |
| **Woolworths** |  |
| **Other** 🡪 specify: |  |

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| **EATING OUT** | | | | | | | | | |
| **Venue** | | **Where:**  (Name and location) | | | **When:**  (date and time) | | | **What:**  (did you eat) | |
| **Restaurants, cafés**  Yes 🡪  No  Unknown | |  | | |  | | |  | |
| **Bakeries**  Yes 🡪  No  Unknown | |  | | |  | | |  | |
| **Takeaways**  (including service stations, fast food)  Yes 🡪  No  Unknown | |  | | |  | | |  | |
| **Continental deli or speciality grocer**  Yes 🡪  No  Unknown | |  | | |  | | |  | |
| **Farmers market or direct from farm**  Yes 🡪  No  Unknown | |  | | |  | | |  | |
| **Social gatherings**  (festivals, weddings, parties, religious events, work conferences)  Yes 🡪  No  Unknown | |  | | |  | | |  | |
| **SHELLFISH AND RAW SEAFOOD** | | | | | | | | | |
| **Food item** | **Response** | | **Date eaten (or frequency)** | **Details** | | **Packaging and brand** | | | **Where purchased**  (supermarket, take away, restaurant, market, home delivery)  **OR Where eaten**  (location, function type) |
| **Any shellfish**  (oysters, mussels, clams, scallops, prawns, abalone, crab, lobster, etc.) | Yes 🡪  No  Unknown | | / / | specify:  **How were they eaten?**  Raw  Partially cooked  Cooked  Unknown | | Brand:  **How purchased?**  Fresh  Frozen  Canned/bottled  Preserved | | |  |
| **FRUIT** (Eaten at home or in a café - May be in foods/desserts e.g. cakes, smoothies, ice cream, yoghurt, syrup) | | | | | | | | | |
| **Fresh berries** | Yes 🡪  No  Unknown | | / / | Strawberry  Raspberry  Blackberry  Blueberry  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown | | |  | |  |
| **Frozen berries** | Yes 🡪  No  Unknown | | / / | Mixed berries  Strawberry  Raspberry  Blackberry  Blueberry  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown | | |  | |  |
| **Other frozen fruit** | Yes 🡪  No  Unknown | | / / | Pomegranate arils  Mango  Pineapple chunks  Banana chunks  Pitted cherries  Acai puree  Coconut pieces  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown | | |  | |  |
| **Commercial frozen smoothie mix** | Yes 🡪  No  Unknown | | / / | Detail ingredients: | | |  | |  |
| **Smoothie mix with frozen ingredients at home** | Yes 🡪  No  Unknown | | / / | Detail ingredients: | | |  | |  |
| **Smoothies and dairy drinks outside the home**  (including yoghurt, milkshakes, etc. from a juice bar or cafe) | Yes 🡪  No  Unknown | | / / | Detail ingredients: | | |  | |  |
| **Other** | | | | | | | | | |
| **Food item** | **Response** | | **Date eaten (or frequency)** | **Type** | | **Packaging and brand** | | | **Where purchased**  **OR Where eaten** |
| **Dried tomatoes**  (May be in pesto, pasta salad, sandwiches, antipasto mix) | Yes 🡪  No  Unknown | | / / | Sun dried  Semi dried  Other  Unknown | | Loose  Bagged  Bottled  Other  Unknown | | |  |
| **Dates** | Yes 🡪  No  Unknown | | / / |  | | Loose  Bagged  Other  Unknown | | |  |
| **Frozen vegetables** | Yes 🡪  No  Unknown | | / / | Corn  Peas  Green Beans  Mixed veg - specify: \_\_\_\_\_\_\_\_\_  Other - specify: \_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown | |  | | |  |
| **Specialty foods made overseas** | Yes 🡪  No  Unknown | | / / | Specify: | |  | | |  |

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| **SECTION 8: HIGH RISK GROUPS AND EXCLUSION** | | | |
| **Infectious period**: (2 weeks prior to first symptom onset to either 1 week after jaundice or 2 weeks after onset of symptoms if no jaundice)  Dates of infectious period: \_\_\_\_/\_\_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_\_\_/\_\_\_\_ | | | |
| **High risk group?**  Yes 🡪 **Continue Section 8**  No 🡪 **Skip to Section 9** | | | |
| **If yes, tick all that apply:**  Commercial food handler  Lives or works in institutional setting 🡪  Healthcare worker  Child care worker  Child in child care / pre-school  Child in primary school | | Institution type:  Hospital  Aged care  Mental health facility  Hostel/boarding house  Correctional facility  Other - specify: | |
| Name of institution: |  | Tel: |  |
| Address: |  | Fax: |  |
| Contact person: |  | Email: |  |
| Attended during infectious period:  Yes  No  If yes, specify dates and location/duties: | | | |
| Information and advice on hep A provided to premises/institution/child care centre/pre-school? | | Yes  No  N/A | |
| Letter sent to contacts at premises/institution/child care centre/primary school? | | Yes  No  N/A  **Attach details/list of who received letter** | |
| Prophylaxis advised for contacts at premises/institution/child care centre/primary school? | | Yes  No  N/A  **Attach details/list of those eligible for prophylaxis and cut-off date(s), and complete summary under Section 10** | |
| Other public health actions | | Specify: | |

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| **ON-SITE INSPECTION REQUIRED AT FOOD PREMISES/CHILD CARE/PRE-SCHOOL/OTHER** | |
| Attendance requested:  Yes  No  N/A | |
| Date requested: / / | Authority:  Contact person: |
| Date of inspection: / / | Date authority provided feedback: / /  **Attach details of inspection** |

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| **EXCLUSION** | |
| **If case is a food handler, health care worker, child in child care, child in primary school or child care worker:**  **EXCLUDE** until at least 7 days after the onset of jaundice OR 2 weeks from onset of prodromal symptoms if no jaundice.  Cases should be informed infectivity may continue beyond official cut-off date | |
| Date exclusion ends: | / / |
| Exclusion discussed with case/guardian | Yes  No  N/A |

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| **ISOLATION** | |
| **If case is a resident of an institution e.g. aged care facility, residential care unit, correctional facility, etc.:**  As far as practicable, **ISOLATE** from well residents until at least 7 days after the onset of jaundice OR 2 weeks from onset of prodromal symptoms if no jaundice.  Please note: Cases should be informed infectivity may continue beyond official cut-off date | |
| Date isolation ends: | / / |

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| **SECTION 9: EDUCATION (ALL CASES)** | |
| **Provide information on the nature of the infection and mode of transmission.**  **Education should include information about restrictions and hygienic practices, particularly hand washing.**  **Whilst infectious, we advise you to:**   * Not donate blood * Practice good hand hygiene * Not prepare or handle food for other people * Not provide personal care to others * Not attend school or work * Not share utensils, towels or personal items with others * Not swim in any pools or other water bodies * **Only for cases 18 years and over** - Not have sex * Not share drugs or drug equipment | |
| Hygiene and preventing transmission discussed | Yes  No  N/A |
| Information fact sheet provided to case | Yes  No  N/A |
| Privacy information requested by case: | Yes  No  N/A |

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| **SECTION 10: CONTACT MANAGEMENT** | |
| People diagnosed with hepatitis A are generally considered infectious from two weeks before the onset of prodromal symptoms to **either** one week after the onset of jaundice (if present) **or** two weeks after the onset of prodromal symptoms if no jaundice occurs. | |
| Infectious period: \_\_\_\_/\_\_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_\_\_/\_\_\_\_ | |
| For this period, please list contacts in table overleaf: | |
| **Contacts are not routinely subject to enforced exclusions. Contacts can be advised to voluntarily exclude themselves from high risk settings, practice good hand hygiene and curb high risk behaviours or work practices until infectious period ends. Individual risk assessment should be utilised to inform contacts of the likelihood of getting hepatitis A and the threat they pose to others. Formalised risk assessments should be undertaken when the case is in a high risk occupation. Further information on the specific circumstances when risk assessments should be undertaken and general principles for decision making are detailed in the HAV SoNG.**  Persons considered to be **contacts** include;   * Immediate family, household members and sexual partners, including people who stayed and shared the primary household facilities with the case * Persons who consumed ready to eat food or drink prepared by the case * If the case wears nappies, persons who provided direct care to the case * If the case attends child care or preschool, other children and adults in the same classroom or care group, or those who share the same toilet may be considered house-hold like * Those who shared intimate personal items or drug equipment with the case.   **Prophylaxis is not indicated for contacts of sporadic cases in the school or work settings, where these conditions are not met.**  **\*In certain circumstances it may be necessary to identify/follow up patrons who have eaten at a food premises where an infectious food handler has been working.**  **Refer to the Hepatitis A SoNG and local jurisdictional guidelines in order to determine whether identified contacts are eligible to receive post exposure Prophylaxis** **(PEP) – (Normal Human Immune Globulin (NHIG) or monovalent inactivated hepatitis A vaccine).** | |
| **Summary:** | |
| How many contacts**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How many require prophylaxis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many require Ig: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How many received Ig: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many require vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How many received vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| For more information and detailed recommendations please consult the hepatitis A national guidelines for public health units (SoNG) available at the Commonwealth Health Department Website. | |

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| **Contact** | **Contact with case** | **Occupation or School/Child care** | **Prophylaxis** |  |
| Name:  Address:  Phone number:  Date of birth: / /  Sex:  Male  Female  Other | Type of contact with case:  Date of last contact with case:  / /  Relationship to case: | **High risk?**  Yes 🡪 Address:    No  Unknown | Prophylaxis required?  Yes  No  Type:  Vaccine  Ig  Parental consent?  Yes  No  N/A | Date given: / /  By whom:  Advice letters sent  Yes  No  N/A  If yes, date: / / |
| Name:  Address:  Phone number:  Date of birth: / /  Sex:  Male  Female  Other | Type of contact with case:  Date of last contact with case:  / /  Relationship to case: | **High risk?**  Yes 🡪 Address:    No  Unknown | Prophylaxis required?  Yes  No  Type:  Vaccine  Ig  Parental consent?  Yes  No  N/A | Date given: / /  By whom:  Advice letters sent  Yes  No  N/A  If yes, date: / / |
| Name:  Address:  Phone number:  Date of birth: / /  Sex:  Male  Female  Other | Type of contact with case:  Date of last contact with case:  / /  Relationship to case: | **High risk?**  Yes 🡪 Address:    No  Unknown | Prophylaxis required?  Yes  No  Type:  Vaccine  Ig  Parental consent?  Yes  No  N/A | Date given: / /  By whom:  Advice letters sent  Yes  No  N/A  If yes, date: / / |

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| **Contact** | **Contact with case** | **Occupation or School/Child care** | **Prophylaxis** |  |
| Name:  Address:  Phone number:  Date of birth: / /  Sex:  Male  Female  Other | Type of contact with case:  Date of last contact with case:  / /  Relationship to case: | **High risk?**  Yes 🡪 Address:    No  Unknown | Prophylaxis required?  Yes  No  Type:  Vaccine  Ig  Parental consent?  Yes  No  N/A | Date given: / /  By whom:  Advice letters sent  Yes  No  N/A  If yes, date: / / |
| Name:  Address:  Phone number:  Date of birth: / /  Sex:  Male  Female  Other | Type of contact with case:  Date of last contact with case:  / /  Relationship to case: | **High risk?**  Yes 🡪 Address:    No  Unknown | Prophylaxis required?  Yes  No  Type:  Vaccine  Ig  Parental consent?  Yes  No  N/A | Date given: / /  By whom:  Advice letters sent  Yes  No  N/A  If yes, date: / / |
| Name:  Address:  Phone number:  Date of birth: / /  Sex:  Male  Female  Other | Type of contact with case:  Date of last contact with case:  / /  Relationship to case: | **High risk?**  Yes 🡪 Address:    No  Unknown | Prophylaxis required?  Yes  No  Type:  Vaccine  Ig  Parental consent?  Yes  No  N/A | Date given: / /  By whom:  Advice letters sent  Yes  No  N/A  If yes, date: / / |

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| **SECTION 11: INVESTIGATION NOTES** |
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