State of California-Health and Human Services Agency

California Department of Public Health
Sexually Transmitted Diseases (STD) Control Branch
850 Marina Bay Parkway
Building P, 2nd Floor
Richmond, CA 94804-6403

Submit to local health department

PERINATAL HEPATITIS C CASE REPORT

This form is to be used for children age 2-36 months found to be infected with hepatitis C virus (HCV).

PART 1: CHILD INFORMATION

1. LAST NAME*	2. FIRST NAME*	3. MIDDLE NAME	4. DATE OF BIRTH*
			MM / DD /

5. STREET ADDRESS	6. APT NUMBER	7. CITY	8. ZIP	9. COUNTY*

10. GENDER*
- ☐ Female
- ☐ Male
- ☐ Unknown
- ☐ FTM Transgender
- ☐ MTF Transgender
- ☐ Other

11. ETHNICITY*
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

12. RACE* *(select all that apply)*
- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ Other
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Unknown

13. REASON FOR CHILD'S HCV TEST? (select all that apply)
- ☐ Gestational parent**** has hepatitis C
- ☐ Suspected healthcare exposure
- ☐ Exposure to a case
- ☐ Other (specify): _____
- ☐ Symptoms of acute hepatitis
- ☐ Evaluation of liver enzyme
- ☐ Unknown

PART 2: CHILD CLINICAL INFORMATION

14. DOES THIS CHILD HAVE OR HAS THE CHILD BEEN LINKED TO A REGULAR HEALTHCARE PROVIDER?
- ☐ Yes
- ☐ No
- ☐ Unknown

LAB TESTS	*Positive*	*Negative*	*Unknown*	*Test Date*
15. HCV Antibody (Anti-HCV)	☐	☐	☐	MM / DD /
16. HCV RNA**	☐	☐	☐	MM / DD /
17. HCV Genotype	☐	☐	☐	MM / DD /
18. HCV Antigen***	☐	☐	☐	MM / DD /

19. PROVIDER NAME	20. PROVIDER SPECIALTY	21. PROVIDER FACILITY	22. PROVIDER PHONE NUMBER
19a.	20a.	21a.	22a.
19b.	20b.	21b.	22b.

PART 3: CASE CLASSIFICIATION

Select the case classification for this individual:*

☐ **CONFIRMED PERINATAL HEPATITIS C:** Individuals who meet all of the conditions in the following case definition:
- Age 2-36 months of age
- Positive test for HCV RNA **OR** HCV antigen*** **OR** detectable HCV genotype during 2-36 months of age
- Not known to have been exposed to HCV via a mechanism other than perinatal

☐ **SUSPECTED PERINATAL HEPATITIS C:** Individuals who do not meet the above case definition but who meet all of the following conditions:
- Age 2-36 months of age
- Positive test for HCV antibody

☐ **NOT A CASE:** Individual does not meet the conditions for a Confirmed or Suspected Perinatal Hepatitis C case.

* Required field
** Ribonucleic acid (RNA)
*** When and if a test for HCV antigen(s) is approved by the U.S. Food and Drug Administration (FDA) and available
**** "Gestational parent" refers to the individual who gave birth to the child.

PART 4: GESTATIONAL PARENT** INFORMATION**

23. LAST NAME	24. FIRST NAME	25. MIDDLE NAME	26. DATE OF BIRTH
			MM / DD /

27. TRIMESTER OF FIRST PRENATAL CARE VISIT FOR THIS PREGNANCY?
☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ No prenatal care visits ☐ Unknown

28. IF THE GESTATIONAL PARENT HAS AN EXISTING DISEASE INCIDENT FOR ANY OF THE FOLLOWING DISEASES, PLEASE ENTER THEIR CORRESPONDING DISEASE INCIDENT ID NUMBER(S):

28a. Acute or Chronic Hepatitis C Disease Incident ID Number	28b. HIV Disease Incident ID Number

29. DOES THE GESTATIONAL PARENT HAVE A REGULAR HEALTHCARE PROVIDER?
☐ Yes
☐ No
☐ Unknown

LAB TESTS	*Positive*	*Negative*	*Unknown*	*Test Date*
30. HCV Antibody (Anti-HCV)	☐	☐	☐	MM / DD /
31. HCV RNA**	☐	☐	☐	MM / DD /
32. HCV Genotype	☐	☐	☐	MM / DD /
33. HCV Antigen***	☐	☐	☐	MM / DD /

34. PROVIDER NAME	35. PROVIDER SPECIALTY	36. PROVIDER FACILITY	37. PROVIDER PHONE NUMBER
34a.	35a.	36a.	37a.
34b.	35b.	36b.	37b.

PART 5: CHILD'S LEGAL PARENT/GUARDIAN

38. IS THE GESTATIONAL PARENT ALSO THE CHILD'S LEGAL GUARDIAN? ☐ Yes ☐ No ☐ Unknown
If no, please list the child's legal guardian(s):

39. LEGAL PARENT/GUARDIAN NAME	40. LEGAL PARENT/GUARDIAN EMAIL ADDRESS	41. LEGAL PARENT/GUARDIAN HOME PHONE NUMBER	42. LEGAL PARENT/GUARDIAN CELL PHONE NUMBER
39a.	40a.	41a.	42a.
39b.	40b.	41b.	42b.

PART 6: INVESTIGATOR INFORMATION

43. INVESTIGATOR NAME	44. JURISDICTION*	NOTES
	45. DATE* MM / DD /	

PERINATAL HEPATITIS C INFORMATION

Clinical Symptoms
Signs and symptoms of perinatal HCV may range from asymptomatic to fulminant hepatitis. Acute HCV infection can progress to chronic infection. Chronically infected persons are thought to be the main reservoir for new infections.

Modes of Transmission
HCV is most often transmitted by percutaneous exposure to blood from a person with HCV infection. Most new HCV infections in the United States are related to sharing injection drug use equipment. Some infections are due to healthcare exposures. Infection via sexual contact or perinatal transmission is possible but uncommon; these modes of transmission are more common in the presence of HIV co-infection. Evidence suggests that the rate of transmission from HCV-infected, HIV-negative gestational parents is approximately 6 percent and from HCV/HIV co-infected gestational parents approximately 11 percent.

Incubation Period
Among those who develop symptoms following exposure to HCV, the average period from exposure to symptom onset is 2-12 weeks (range: 2-26 weeks). Most people with chronic HCV infection are asymptomatic and many eventually develop chronic liver disease slowly without any signs or symptoms for several decades.

Period of Communicability
An individual is considered infectious anytime HCV RNA is present in the blood. HCV RNA can be detected in the blood or plasma 1 to 2 weeks after exposure. Approximately 15 percent –25 percent of people clear the virus from their bodies without treatment and do not develop chronic infection. The remainder will have HCV RNA and remain infectious unless treated and cured.

HCV Testing Guidelines in Children
Available guidelines consistently recommend against antibody testing for children under 18 months of age due to transient maternal HCV antibody that may not indicate actual infection status of the child. Infants who test positive for HCV antibody should also be tested for HCV RNA to confirm HCV infection.