ICMR-NATIONAL INSTITUTE OF VIROLOGY

Acute Hepatitis Case Reporting Form (CRF)- CASE PROFORMA

Please fill all the Mandatory fields marked with an (*)

*Referring hospital name/location: _____State/Region: _____Date:_____

Referring doctor details: Name *Dr.*_____, Email ID:_____ Phone no. _____

Tests requested: □ HAV-IgM □HAV-IgG □HAV Real time (Qualitative) □HBsAg □Anti-HBs □HBV Real time (Qualitative)

□HBV Real time (Quantitation) Viral Load □HEV-IgM □HEV-IgG □HEV Real time (Qualitative)

□ anti-HCV antibodies □ HCV Real time (Qualitative) □HCV RNA Genotyping

*PATIENT NAME: _____ AGE: _____ months/year GENDER: Male / Female

Mobile number: _____ Occupation: _____

Whether Case from: □ Out-patient department (OPD) □ Inpatient Department (IPD)/ Admitted

If admitted, patient transferred to current facility from another facility? ☐Yes ☐No ☐Unknown

If yes, name of referring facility_____ Admission date at the first facility _____

If female, whether pregnant? □ Yes □ No If yes, which trimester? □ First □ Second □ Third

*DATE OF ONSET OF INITIAL SYMPTOMS	
Date of first/earliest symptom: _____	First Symptom: _____
SYMPTOMS	
Fever □ Yes □ No If yes, date of onset:	Pale stool □Yes □ No If yes, date of onset:
Yellow eyes/Scleral icterus □Yes □ No If yes, date of onset:	Dark-coloured urine □Yes □ No If yes, date of onset:
Decreased appetite/anorexia □Yes □ No If yes, date of onset:	Abdominal pain □Yes □ No If yes, date of onset:
Jaundice □Yes □ No If yes, date of onset :	Muscle aches/myalgia □Yes □ No If yes, date of onset:
Fatigue/ Weakness □Yes □ No If yes, date of onset:	Nausea/ Giddiness □Yes □ No If yes, date of onset:

*CLINICAL EVALUATION: SYMPTOMS/SIGNS (If patient admitted/hospitalized)	
SIGNS/SYMPTOMS	
Peripheral oedema □ Yes □ No If yes, date of onset:	Palmar erythema □ Yes □ No If yes, date of onset:
Hepatomegaly □ Yes □ No If yes, date of onset:	Caput medusa □ Yes □ No If yes, date of onset:
Splenomegaly □ Yes □ No If yes, date of onset:	Pale stool □ Yes □ No If yes, date of onset:
Ascites □ Yes □ No If yes, date of onset:	Dark-coloured urine □ Yes □ No If yes, date of onset:
Lymphadenopathy □ Yes □ No If yes, date of onset:	Asterixis (flapping hands /tremor) □ Yes □ No If yes, date of onset:

*LABORATORY TESTING CONDUCTED AT SITE		
ALT/ SGOT (U/L)	**Blood urea nitrogen (mg/dL)**	**INR (International Normalized Ratio)**
AST/SGPT (U/L)	**Albumin (g/dL)**	**Prothrombin time**
Total bilirubin (mg/dL)	**Uric acid (mg/dL)**	**Activated partial thromboplastin time (aPTT)**
Alkaline phosphatase (U/L)	**Ammonia (umol/L)**	**Fibrinogen (mg/dL)**
Glucose (mg/dL)	**Lactate (mmol/L)**	**Any other tests:**
Creatinine (mg/dL)		

Whether tested for hepatotrophic viruses tested at site?

Hepatotrophic virus	Tests conducted	Test results
Hepatitis A virus		
Hepatitis B virus		
Hepatitis C virus		
Hepatitis D virus		
Hepatitis E virus		

***Samples being sent to Hepatitis Group, ICMR-NIV for testing**		
Specimen	**Quantity being sent (No. of vials/containers)**	**Date of collection**
Whole blood □Yes □ No		
Serum □Yes □ No		
Stool sample □Yes □ No		
Water sample (Environmental) □Yes □ No		

EXPOSURE HISTORY	
Exposure to hepatotoxic drugs/ agents (Paracetamol/ Acetaminophen/ Anticox (TB)/ Antiepileptic) □Yes □ No	History of blood transfusion/injection □ Yes □ No If yes, details:
History of Tattooing □ Yes □ No	Consumption of outside food over past few weeks □ Yes □ No
History of undergoing surgical procedure □Yes □ No	History of alcoholism Yes □ No If yes, duration: _____ years
Recent contact with acute hepatitis patient □Yes □ No If yes, relation:	History of recent travel □ Yes □ No If yes, when and where:
Intravenous drug user □ Yes □ No If yes, since: _____ years	Drinking water source: □ Municipal supply by tap □ Well □ Common community source

***Are features of ACUTE LIVER FAILURE (ALF) present?**
Acute impairment of liver function (INR > 1.5) unresponsive to vitamin K, with or without (> 2) encephalopathy □ Yes □ No
IF yes, please fill the details below:

Other signs/symptoms of liver failure

- Fever □Yes □ No If yes, date of onset _____
- Presence of dehydration □Yes □ No If yes, date of onset _____
- Inability to maintain oral hydration □Yes □ No If yes, date of onset _____
- Not passing urine □Yes □ No If yes, date of onset _____
- Severe or persistent nausea and vomiting □Yes □ No If yes, date of onset _____
- Repeated episodes of hypoglycaemia □Yes □ No If yes, date of onset _____
- Spontaneous bleeding (nasal, oral, vaginal, bloody diarrhoea and vomiting) □Yes □ No If yes, date of onset _____
- Variceal bleed □Yes □ No If yes, date of onset _____

MENTAL STATE CHANGES/EVIDENCE OF ENCEPHALOPATHY

Excessive sleepiness, irritability, agitation, disorientation, confusion, abnormal behaviour or decreased level of consciousness

If yes, then grading of encephalopathy

Grade 1	Irritable, apathetic, behavioural and sleep disturbance
Grade 2	Drowsy, confused, but responds to commands
Grade 3	Severely confused or agitated, but response to pain
Grade 4	Unrousable, no response to pain

COMPLICATIONS	**Yes**	**No**
Multisystem involvement		
Renal failure		
Haemodynamic changes		
Pulmonary complications		
Cardiac complication		
Any other complications	Details, if yes:	