

NSW Hepatitis A Questionnaire

National OzFoodNet enhanced Hepatitis A surveillance pilot



Date of notification:		NCIMS ID:	
Date of interview:		Interviewer:	
Person interviewed (if not case):		NCIMS updated:	
High risk group* (see section 8): *Includes food handlers, healthcare workers, institutional residents, child care workers, children in child care or primary school		Is there an epi link to a confirmed case? NCIMS ID of epi-linked case:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sporadic case:	Yes <input type="checkbox"/> No <input type="checkbox"/> → outbreak (cluster) ID: _____		
Molecular typing performed	Yes <input type="checkbox"/> → genotype: _____ No <input type="checkbox"/>		
Case status:	Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Excluded <input type="checkbox"/>		
Probable source:			

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 NSW Health.

SECTION 1: DEMOGRAPHIC DATA			
Surname:		Other names:	
Date of birth:	/ /	Age:	
Sex:	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	Parent/carer name (if applicable):	
Street address:		Suburb:	
		Postcode:	
Home Tel:		Work Tel:	
Mobile:		Email:	
Country of birth:		Year of arrival in Australia (if born overseas):	
Language spoken at home:		Interpreter required?	Yes <input type="checkbox"/> → Language: _____ No <input type="checkbox"/>
Are you of Aboriginal and/or Torres Strait Islander origin?	<input type="checkbox"/> Yes, Aboriginal but not Torres Strait Islander <input type="checkbox"/> Yes, Torres Strait Islander but not Aboriginal <input type="checkbox"/> Yes, Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Not Indigenous <input type="checkbox"/> Unknown <input type="checkbox"/> Not stated		
Occupation (full-time or part-time work, voluntary activities) / school / child care:	<input type="checkbox"/> Child in child care/pre-school <input type="checkbox"/> Student - primary <input type="checkbox"/> High-risk occupation* <i>(*includes healthcare workers, food handlers, child care workers)</i> ↓ Record additional details in Sections 7 and/or 8 where applicable	<input type="checkbox"/> Child at home <input type="checkbox"/> Student – secondary: _____ <input type="checkbox"/> Student - other: _____ <input type="checkbox"/> Occupation - other: _____	
Case status:	<input type="checkbox"/> Alive <input type="checkbox"/> Died due to notifiable disease → <input type="checkbox"/> Died due to other/unknown causes → <input type="checkbox"/> Unknown	Cause of death (if known): Date of death:	

SECTION 2: LABORATORY INVESTIGATIONS

Test	Collection date	Laboratory	Lab ID	Result
Serology <input type="checkbox"/> Tested <input type="checkbox"/> Not tested	/ /			<input type="checkbox"/> IgM detected <input type="checkbox"/> IgM not detected <input type="checkbox"/> IgG detected <input type="checkbox"/> IgG not detected
PCR (HAV RNA) <input type="checkbox"/> Tested <input type="checkbox"/> Not tested	/ /			<input type="checkbox"/> RNA detected <input type="checkbox"/> RNA not detected
Liver function tests <input type="checkbox"/> Tested <input type="checkbox"/> Not tested	/ /			Bilirubin: ALT: ALP: AST: GGT:
Specimen referred to VIDRL for molecular typing:	Yes <input type="checkbox"/> → date: / / No <input type="checkbox"/> → reason:			

SECTION 3: GENERAL PRACTITIONER

Name of doctor:		Name of clinic:	
Clinic address:		Clinic Tel:	
		Fax:	
		Email:	

SECTION 4: HOSPITAL PRESENTATION

Did the case present to the Emergency Department?	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No	Name of hospital:	
Was the case admitted to hospital?	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No	Hospital record no:	
Ward:		Date of discharge / death: (<i>circle</i>)	
Name of treating doctor/team:		Contact no:	

CONSENT BY TREATING DOCTOR*

Doctor has provided consent to contact the case:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Name of doctor providing consent:		Date consent provided:	
Is the doctor aware of the case's hep A vaccination status?	<input type="checkbox"/> Vaccinated → record details in section 6 <input type="checkbox"/> No record of vaccination		
Is the doctor aware of the case's sexual orientation?	<input type="checkbox"/> Yes → record details in section 8 → If case is MSM, has STI screening been arranged? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No		
*Obtain preliminary information from treating doctor on illness and risk exposures: sections 5 to 8.			

SECTION 5: ILLNESS

Symptom		Onset date
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /
Diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /

Abdominal pain/discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Anorexia (loss of appetite) / Weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Malaise / lethargy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Dark urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Pale faeces	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	/	/
Other symptoms (please specify):				/	/
History of illness					

SUMMARY OF ILLNESS					
Date of first symptom onset:		Date of jaundice onset:			
Exposure period (15 to 50 days prior to first symptom onset)	/	/	to	/	/
Infectious period (2 weeks prior to first symptom onset to 1 week after jaundice or 2 weeks after onset of symptoms if no jaundice)"	/	/	to	/	/

SECTION 6: VACCINATION HISTORY					
Received hep A vaccination previously		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, as post-exposure prophylaxis			
Dose 1 date:	/ /	Validated by:	<input type="checkbox"/> doctor <input type="checkbox"/> practice records <input type="checkbox"/> AIR		
Dose 2 date:	/ /	Validated by:	<input type="checkbox"/> doctor <input type="checkbox"/> practice records <input type="checkbox"/> AIR		
Dose 3 date:	/ /	Validated by:	<input type="checkbox"/> doctor <input type="checkbox"/> practice records <input type="checkbox"/> AIR		
Has the case received immunoglobulin in the past 4 weeks?		<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> Unknown			
NOTE: A 2 dose vaccination schedule is given for monovalent HAV vaccines <u>and</u> for combination HAV and Typhoid vaccines. A 3 dose schedule is given for combination HAV and HBV vaccines.					

SECTION 7: RISK FACTORS DURING EXPOSURE PERIOD			
Exposure period (between 15 and 50 days prior to onset of illness): ___/___/___ to ___/___/___			
Did you travel during any part of your exposure period?	<input type="checkbox"/> Yes - Domestic travel → where:	Departure date:	___/___/___
	<input type="checkbox"/> Yes - International travel → where:	Return date: <i>(if multiple places, specify arrival and departure dates for each location)</i>	___/___/___
	<input type="checkbox"/> No	<i>International travellers only:</i>	<input type="checkbox"/> Yes → Skip to Section 9
	<input type="checkbox"/> Unknown	Did the case spend their entire exposure period overseas?	<input type="checkbox"/> No <input type="checkbox"/> Unknown

Did you have household contact, casual contact or sexual contact with anyone who had recently travelled?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	What type of contact? <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Casual	<input type="checkbox"/> Domestic travel <input type="checkbox"/> International travel	Places visited:
		Name of traveller:	Relationship of traveller to case:	
		Departure Date: / / Return Date: / /	Did the traveller have any symptoms similar to you? <input type="checkbox"/> Yes - approximate onset date / / <input type="checkbox"/> No	
Did you have household contact, casual contact or sexual contact with a person known or suspected to have hepatitis A?	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name:	NCIMS ID:	
		Relationship to case:	<input type="checkbox"/> Confirmed case <input type="checkbox"/> Suspected case	
		Type/place of contact:	Did you receive HAV vaccine as prophylaxis? <input type="checkbox"/> Yes → Date administered: / / <input type="checkbox"/> No <input type="checkbox"/> Not applicable (suspected HAV only)	

SECTION 8a: SUPPLEMENTARY RISK FACTORS DURING EXPOSURE PERIOD – Non-food exposures

Exposure period (between 15 and 50 days prior to onset of illness):
 ___/___/___ to ___/___/___

NB: * Both doctors and cases should be asked this question; ^ Additional details should be completed in Section 9 for these risk factors

Risk factor	Details	
Household or close contact of someone known to have gastroenteritis	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name: Relationship to case/type of contact: Contact number:
Household contact with child under 5 years old	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Does this child attend child care/preschool? <input type="checkbox"/> Yes → Name of child care/preschool: <input type="checkbox"/> No
Non-household contact with child under 5 years old	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Child's name and contact number: Does this child attend child care/preschool? <input type="checkbox"/> Yes → Name of child care/preschool: <input type="checkbox"/> No
Exposure to untreated sewage (e.g. sewage worker)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Exposure activity: Date: ___/___/___
*An inpatient in hospital	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of facility: Dates of admission/discharge:
*Received a transfusion of blood products	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of facility: Date of transfusion: Blood product transfused:
*Marijuana use	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you share drugs or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Details of regular contacts: Risk factor reported by: <input type="checkbox"/> Doctor <input type="checkbox"/> Case <input type="checkbox"/> Both <input type="checkbox"/> Other

*Injecting drug use	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you share drugs or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Details of regular contacts: Reported by: <input type="checkbox"/> Doctor <input type="checkbox"/> Case <input type="checkbox"/> Both <input type="checkbox"/> Other
*Any sexual contact	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	With a person of which gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Reported by: <input type="checkbox"/> Doctor <input type="checkbox"/> Case <input type="checkbox"/> Both <input type="checkbox"/> Other
*Male to male sexual contact	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Regular partner: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Casual partner: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Do you visit any sex venues? (e.g. sex on premises venues (SOPVs), saunas, cruising grounds, festivals, private sex parties) <input type="checkbox"/> Yes → Name of sex venue/s: <input type="checkbox"/> No <input type="checkbox"/> Unknown Date/s of visit:
		Do you use social networking sites to meet partners: <input type="checkbox"/> Yes → which apps (e.g. Grindr, Tinder): <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Are you enrolled in the EPIC-NSW study? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Risk factor reported by: <input type="checkbox"/> Doctor <input type="checkbox"/> Case <input type="checkbox"/> Both <input type="checkbox"/> Other
*Sex work or sexual contact with sex worker	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Risk factor reported by: <input type="checkbox"/> Doctor <input type="checkbox"/> Case <input type="checkbox"/> Both <input type="checkbox"/> Other
^Institutional resident	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	^Record details of the institution in Section 9
^Healthcare worker	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Duties and areas of work (e.g. wards): ^Record details of the institution in Section 9
^Child in child care/preschool	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Does the child wear nappies? <input type="checkbox"/> Yes <input type="checkbox"/> No Room/age group: ^Record details of the institution in Section 9
^Child in primary school	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Class: ^Record details of the institution in Section 9
^Child care worker or preschool teacher	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you change nappies? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you prepare or handle food? <input type="checkbox"/> Yes <input type="checkbox"/> No Room or age group case spends most time with: ^Record details of the institution in Section 9
^Association with a prison or remand centre	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Resident <input type="checkbox"/> Visitor <input type="checkbox"/> Staff Details and dates of contact: ^Record details of the institution in Section 9

SECTION 8: 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.

<p>During this period did you purchase your groceries from:</p>	<p>Aldi <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Coles <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown IGA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Woolworths <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p style="text-align: center;">↳ Specify: Location/s of stores:</p>
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Shellfish, molluscs and raw seafood

Food item	Response	Date eaten (or frequency)	Details	Packaging and brand	Where purchased from (supermarket, take away, restaurant, food trucks, market, home delivery) OR Where eaten (location, function type) including free food samples
Oysters	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	How were they eaten? <input type="checkbox"/> Raw <input type="checkbox"/> Partially cooked <input type="checkbox"/> Cooked <input type="checkbox"/> Unknown	How purchased? <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Canned/bottled <input type="checkbox"/> Preserved Brand:	
Mussels	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	How were they eaten? <input type="checkbox"/> Raw <input type="checkbox"/> Partially cooked <input type="checkbox"/> Cooked <input type="checkbox"/> Unknown	How purchased? <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Canned/bottled <input type="checkbox"/> Preserved Brand:	
Other Shellfish	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	Clams <input type="checkbox"/> Raw <input type="checkbox"/> Partially cooked <input type="checkbox"/> Cooked <input type="checkbox"/> Unknown	How purchased? <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Canned/bottled <input type="checkbox"/> Preserved Brand:	
			Pippies <input type="checkbox"/> Raw <input type="checkbox"/> Partially cooked <input type="checkbox"/> Cooked <input type="checkbox"/> Unknown	How purchased? <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Canned/bottled <input type="checkbox"/> Preserved Brand:	
			Scallops <input type="checkbox"/> Raw <input type="checkbox"/> Partially cooked <input type="checkbox"/> Cooked <input type="checkbox"/> Unknown	How purchased? <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Canned/bottled <input type="checkbox"/> Preserved Brand:	

Other Shellfish	Cont.		Other: e.g. prawns, snails, abalone, crab	How purchased? <input type="checkbox"/> Fresh <input type="checkbox"/> Frozen <input type="checkbox"/> Canned/bottled <input type="checkbox"/> Preserved Brand: _____	
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Fresh berries (Eaten at home or in a café - May be in foods/desserts e.g. cakes, smoothies, ice cream, yoghurt, syrup)

Food item	Response	Date eaten (or frequency)	Type	Packaging and brand	Where purchased from OR Where eaten
Fresh berries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	Type of fresh berry: <input type="checkbox"/> Strawberry <input type="checkbox"/> Raspberry <input type="checkbox"/> Blackberry <input type="checkbox"/> Blueberry <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		

Frozen berries and other fruit (Eaten at home or in a café - May be in foods/desserts e.g. cakes, smoothies, ice cream, yoghurt, syrup)

Food item	Response	Date eaten (or frequency)	Type	Packaging and brand	Where purchased from OR Where eaten
Frozen mixed berries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen Strawberries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen Blueberries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen Blackberries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen Raspberries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			

Other frozen fruit (Eaten at home or in a café - May be in foods/desserts e.g. cakes, smoothies, ice cream, yoghurt, syrup)

Food item	Response	Date eaten (or frequency)	Type	Packaging and brand	Where purchased from OR Where eaten
Frozen pomegranate arils	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen pitted Cherries	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen Mango	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			

Frozen Acai Puree	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen pineapple Chunks	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen coconut pieces	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Frozen Banana Chunks	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Commercial frozen smoothie mix	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			
Other frozen fruit	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /			

Smoothies and drinks

Food item	Response	Date eaten (or frequency)	Type	Packaging and brand	Where purchased from OR Where eaten
Smoothie mix with frozen ingredients (at home)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	Detail ingredients:		
Smoothies and dairy drinks outside the home (including milkshakes, yoghurt etc. such as from a juice bar or bought in a cafe)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	Detail ingredients:		

Dried tomatoes

Food item	Response	Date eaten (or frequency)	Type	Packaging and brand	Where purchased from OR Where eaten
Dried tomatoes (May be in pesto, pasta salad, sandwiches, antipasto mix)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Sun dried	<input type="checkbox"/> Loose <input type="checkbox"/> Bagged <input type="checkbox"/> Bottled <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
			<input type="checkbox"/> Semi dried	<input type="checkbox"/> Loose <input type="checkbox"/> Bagged <input type="checkbox"/> Bottled <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
			<input type="checkbox"/> Other or unknown type	<input type="checkbox"/> Loose <input type="checkbox"/> Bagged <input type="checkbox"/> Bottled <input type="checkbox"/> Other <input type="checkbox"/> Unknown	

Other					
Frozen vegetables	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	<input type="checkbox"/> Corn <input type="checkbox"/> Peas <input type="checkbox"/> Green Beans <input type="checkbox"/> Mixed veg – specify: <input type="checkbox"/> Other (specify):		
Specialty/world foods or foods brought from abroad (e.g. falafel, stuffed vine leaves, Indian sweets)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	Specify food:		
Exposure to untreated water (Includes consumption of ice made from untreated water)	<input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown	/ /	Type of exposure: (e.g. drinking, swimming, boating, etc.)		
			Type of water source:		
			Location:		

EATING OUT			
Venue	Date	Name and address of venue/s	Foods eaten
Restaurants <input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Takeaway (inc. food trucks, markets, free food samples) <input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Event (e.g. conference, wedding, festival) <input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Dined at someone else's home <input type="checkbox"/> Yes → <input type="checkbox"/> No <input type="checkbox"/> Unknown			

SUMMARY	
What does the case think caused their illness?	
Potential source of illness as assessed by interviewer	

SECTION 9: HIGH RISK GROUPS AND EXCLUSION

High risk group? Yes → Continue Section 9 No → Skip to Section 10

If yes, tick all that apply: <input type="checkbox"/> Commercial food handler <input type="checkbox"/> Lives or works in institutional setting → <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Child care worker <input type="checkbox"/> Child in child care <input type="checkbox"/> Child in primary school		Institution type: <input type="checkbox"/> Hospital <input type="checkbox"/> Aged care <input type="checkbox"/> Psych facility <input type="checkbox"/> Hostel/boarded house <input type="checkbox"/> Correctional facility <input type="checkbox"/> Military facility <input type="checkbox"/> Other - specify:	
Name of institution:		Tel:	
Address:		Fax:	
Contact person:		Email:	
Date last attended prior to onset: / /		Attended during infectious period:	
Information and advice on hep A provided to premises/institution/child care centre/primary school?		<input type="checkbox"/> Yes → Date provided: / / <input type="checkbox"/> No <input type="checkbox"/> N/A	
Surveillance letter sent to contacts at premises/institution/child care centre/primary school?		<input type="checkbox"/> Yes → Date sent: / / <input type="checkbox"/> No <input type="checkbox"/> N/A Attach details/list of who received letter	
Prophylaxis advised for contacts at premises/institution/child care centre/primary school:?		<input type="checkbox"/> Yes → Date provided: / / <input type="checkbox"/> No <input type="checkbox"/> N/A Attach details/list of those eligible for prophylaxis and cut-off date(s), and complete summary under Section 11	

ON-SITE INSPECTION REQUIRED AT FOOD PREMISES/CHILD CARE/PRE-SCHOOL/OTHER

Attendance requested: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Date requested: / /	Authority: Contact person:
Date of inspection: / /	Date authority provided feedback: : / / Attach details of inspection

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	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> N/A

Exclusion letter sent	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> N/A
Other public health actions	Specify:
Information sent to workplace/school/child care	<input type="checkbox"/> Yes → Date: / / <input type="checkbox"/> No <input type="checkbox"/> N/A

ISOLATION	
<p>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 <u>at least 7</u> 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</p>	
Date isolation ends:	/ /

SECTION 10: EDUCATION (ALL CASES)

Provide information on the nature of the infection and mode of transmission.
 Education should include information about hygienic practices, particularly hand washing.

Hygiene and preventing transmission discussed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Information brochure provided to case	<input type="checkbox"/> Yes → Date sent: <input type="checkbox"/> No <input type="checkbox"/> N/A
Privacy information requested by case:	<input type="checkbox"/> Yes → Date sent: <input type="checkbox"/> No <input type="checkbox"/> N/A

Isolation and restrictions	
Infectious period: ___/___/___ to ___/___/___	
Whilst infectious, we advise you to:	
<u>Not</u> donate blood	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
<u>Not</u> prepare or handle food for other people	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
Practice good hand hygiene	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
<u>Not</u> have sex	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
<u>Not</u> provide personal care to others	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
<u>Not</u> attend preschool, child care school or high risk work	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
<u>Not</u> share utensils, towels or personal items with others	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
<u>Not</u> share drugs or drug equipment	<input type="checkbox"/> Informed <input type="checkbox"/> N/A
If living in a residential, aged care, correctional or similar facility: <u>isolate</u> yourself as much as possible	<input type="checkbox"/> Informed <input type="checkbox"/> N/A

If it is necessary, may we please contact you again?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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SECTION 11: 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 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;

- Household members
- Immediate family
- Sexual partners
- People who shared primary household bathroom facilities with the case
- *People who consumed food not subjected to further cooking that was prepared by the case
- If the case is a food handler, other food handlers in the same establishment
- If the case is in 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
- 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).

<p>Summary:</p> <p>How many contacts _____</p> <p>How many require Ig _____</p> <p>How many require vaccine _____</p>	<p>How many require prophylaxis _____</p> <p>How many received Ig _____</p> <p>How many received vaccine _____</p>
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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.

Name of Interviewer: _____

Signature: _____ Date: ____/____/____

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

Photocopy this page if more contacts are required

Contact page number ____ of ____

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

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Contact page number ____ of ____

