

**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 <u>Dr.</u> _____,		Email ID: _____		Phone no. _____	
Tests requested: <input type="checkbox"/> HAV-IgM <input type="checkbox"/> HAV-IgG <input type="checkbox"/> HAV Real time (Qualitative) <input type="checkbox"/> HBsAg <input type="checkbox"/> Anti-HBs <input type="checkbox"/> HBV Real time (Qualitative)					
<input type="checkbox"/> HBV Real time (Quantitation) Viral Load <input type="checkbox"/> HEV-IgM <input type="checkbox"/> HEV-IgG <input type="checkbox"/> HEV Real time (Qualitative)					
<input type="checkbox"/> anti-HCV antibodies <input type="checkbox"/> HCV Real time (Qualitative) <input type="checkbox"/> HCV RNA Genotyping					
*PATIENT NAME: _____		AGE: _____ months/year		GENDER: Male / Female	
Mobile number: _____		Occupation: _____			
Whether Case from: <input type="checkbox"/> Out-patient department (OPD) <input type="checkbox"/> Inpatient Department (IPD)/ Admitted					
If admitted, patient transferred to current facility from another facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
If yes, name of referring facility _____		Admission date at the first facility _____			
If female, whether pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which trimester? <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third					

**\*DATE OF ONSET OF INITIAL SYMPTOMS**

Date of first/earliest symptom: _____		First Symptom: _____	
SYMPTOMS			
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Pale stool <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Yellow eyes/Scleral icterus <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Dark-coloured urine <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Decreased appetite/anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Muscle aches/myalgia <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Fatigue/ Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Nausea/ Giddiness <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	

**\*CLINICAL EVALUATION: SYMPTOMS/SIGNS (If patient admitted/hospitalized)**

SIGNS/SYMPTOMS			
Peripheral oedema <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Palmar erythema <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Hepatomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Caput medusa <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Splenomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Pale stool <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Ascites <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Dark-coloured urine <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____	
Lymphadenopathy <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset: _____		Asterixis (flapping hands /tremor) <input type="checkbox"/> Yes <input type="checkbox"/> 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 hepatotropic viruses tested at site?**

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

<b>*Samples being sent to Hepatitis Group, ICMR-NIV for testing</b>		
Specimen	Quantity being sent (No. of vials/containers)	Date of collection
Whole blood <input type="checkbox"/> Yes <input type="checkbox"/> No		
Serum <input type="checkbox"/> Yes <input type="checkbox"/> No		
Stool sample <input type="checkbox"/> Yes <input type="checkbox"/> No		
Water sample (Environmental) <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>EXPOSURE HISTORY</b>		
Exposure to hepatotoxic drugs/ agents (Paracetamol/ Acetaminophen/ Anticox (TB)/ Antiepileptic) <input type="checkbox"/> Yes <input type="checkbox"/> No	History of blood transfusion/injection <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details:	
History of Tattooing <input type="checkbox"/> Yes <input type="checkbox"/> No	Consumption of outside food over past few weeks <input type="checkbox"/> Yes <input type="checkbox"/> No	
History of undergoing surgical procedure <input type="checkbox"/> Yes <input type="checkbox"/> No	History of alcoholism Yes <input type="checkbox"/> No If yes, duration: _____ years	
Recent contact with acute hepatitis patient <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, relation:	History of recent travel <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where:	
Intravenous drug user <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, since: _____ years	Drinking water source: <input type="checkbox"/> Municipal supply by tap <input type="checkbox"/> Well <input type="checkbox"/> Common community source	
<b>*Are features of ACUTE LIVER FAILURE (ALF) present? Acute impairment of liver function (INR &gt; 1.5) unresponsive to vitamin K, with or without (&gt; 2) encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No IF yes, please fill the details below:</b>		
<b>Other signs/symptoms of liver failure</b>		
<ul style="list-style-type: none"> <li>• Fever <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Presence of dehydration <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Inability to maintain oral hydration <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Not passing urine <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Severe or persistent nausea and vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Repeated episodes of hypoglycaemia <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Spontaneous bleeding (nasal, oral, vaginal, bloody diarrhoea and vomiting) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> <li>• Variceal bleed <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of onset _____</li> </ul>		
<b>MENTAL STATE CHANGES/EVIDENCE OF ENCEPHALOPATHY</b>		
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	
<b>COMPLICATIONS</b>	<b>Yes</b>	<b>No</b>
Multisystem involvement		
Renal failure		
Haemodynamic changes		
Pulmonary complications		
Cardiac complication		
Any other complications	Details, if yes:	