

Hepatitis A Investigation Checklist for Local Health Departments

Local health department staff should follow these steps, not necessarily always in order, when investigating reports of hepatitis A. For more detailed information refer to the Hepatitis A, acute Disease Chapter. Hepatitis A is a Priority Level 2 disease and critical details should be entered into the Communicable Disease Reporting and Surveillance System (CDRSS) **within 12 hours**.

- Review laboratory details to confirm the test result. If the case has not been submitted via CDRSS, create a case.
- Ensure the case-patient meets criteria based on [NNDSS case definitions](#) for Hepatitis A. If the patient does not meet case definition, no follow-up is needed and the CDRSS case must be closed as “NOT A CASE”.
- Interview the case-patient (parent/guardian if case-patient is a minor) via phone using the *HAV Risk Factors* section. Do not fax this information to the physician or mail to the home of the case-patient for completion.
- Assess the case-patient for high-risk activities (e.g., daycare attendee, food handler) and exclude from school or work in accordance with [NJDOH Exclusion Criteria](#).
- Provide education to the case-patient; additional information can be found on the NJDOH and CDC disease pages.
- Enter critical details (demographics, signs/symptoms, clinical status, additional laboratory information, and industry/occupation) into the CDRSS case.
- Enter relevant exposures (travel, ill contacts, sexual preference and partners, drug use, homelessness) into the *HAV Risk Factors* section within the CDRSS case.
- Notify the appropriate local health department and document in CDRSS if a food establishment, restaurant, etc. from another jurisdiction is identified as a possible source of exposure.
- Inform the Foodborne and Waterborne Disease Unit at cds.fwd.epi@doh.nj.gov if a cluster or outbreak is suspected.
- Enter any additional symptomatic contacts identified through the interview into the *Contact Tracing* section within CDRSS and follow case investigation as appropriate.
- Document dates/times of at least three attempts made to reach the case-patient into the *Comments* section within CDRSS if they remain unreachable.
- Determine *Case Status* based on [NNDSS case definitions](#) and mark *Report Status* as “LHD CLOSED” in CDRSS.

HEPATITIS A SURVEILLANCE CASE REPORT FORM
ENTER DATA FROM THE COMPLETED CASE REPORT FORM INTO CDRSS

Section 1: INTERVIEWER & PATIENT INFORMATION:

1. CDRSS ID: _____ 2. State of residence: _____ 3. County: _____ 4. Zip code: _____

5. Interviewer Information
 Name: _____ Contact Phone Number: (____) ____-____
 Agency or Organization: _____ Date of Interview: ____/____/____ (MM/DD/YYYY)

6. Language interview conducted in English Spanish Other (Specify): _____

7. Respondent was: Self Parent Spouse Other (Specify): _____
 Not interviewed - *If not interviewed, why not?* _____

8. Patient outcome at time of interview: Survived Died Unknown
If died, was this infection considered an underlying, contributing, or immediate cause of death? Yes No Unknown

Section 2: DEMOGRAPHIC DATA:

1. Date of birth: ____/____/____ (MM/DD/YYYY) 2. Age: _____ 3. Sex: Male Female

4. Hispanic or Latino origin? Yes No Unknown

5. How would you describe your (your child's) race?
 White Black / African American American Indian / Alaska Native Unknown
 Asian Native Hawaiian / Other Pacific Islander Other (specify): _____

Section 3: CLINICAL INFORMATION:

1. What date did you (your child) first feel sick? ____/____/____ (MM/DD/YYYY)

2. How many days in total were you (your child) sick? _____ days Unknown Still sick

3. Prior to onset of symptoms, did you (your child) have any long-lasting or chronic illness or condition (an illness that has lasted longer than 1 month)?
 Yes No Unknown Refused *if yes, please specify:* _____

Yes	No	Unk.	Did you (your child) have:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asymptomatic?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramps?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal stool (light, clay-colored)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dark Urine?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea? Start Date: ____/____/____ End Date ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Total Bilirubin Levels (>3.0 mg/dL)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Alanine Aminotransferase (ALT) Levels (>200 IU/L)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever (or felt feverish)? a. Temperature: ____ degrees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaise (Discomfort)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other? a. Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you (your child) hospitalized overnight? (<i>must enter MM/DD/YYYY</i>) a. Hospital Name: _____ b. Admission Date: ____/____/____ Discharge Date: ____/____/____ <input type="checkbox"/> ICU

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Have you ever been vaccinated for Hepatitis A:</p> <p>a. Type of Vaccine: <input type="checkbox"/> Havrix <input type="checkbox"/> Hep A Unspecified Formulation <input type="checkbox"/> Twinrix <input type="checkbox"/> Vaqta</p> <p>b. Date of Vaccination : ____/____/____ (MM/DD/YYYY)</p> <p>c. Source of vaccine info: <input type="checkbox"/> Medical record <input type="checkbox"/> Birth certificate <input type="checkbox"/> Patient or parent's written record</p> <p> <input type="checkbox"/> School record <input type="checkbox"/> NJ Immunization Information System</p> <p> <input type="checkbox"/> New Immunization Record <input type="checkbox"/> Other: _____</p>
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Section 4: RISK FACTORS: [Add to the "HAV Risk Factors" section in CDRSS]

Yes	No	Unk	During the 2-6 weeks prior to illness onset date:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>1. Was the patient in contact with a person with confirmed or suspected hepatitis A infection?</p> <p>a. Type of contact the subject had with a person with confirmed or suspected hepatitis virus infection?</p> <p><input type="checkbox"/> Babysitter <input type="checkbox"/> Child cared for by this patient <input type="checkbox"/> Household member (non-sexual)</p> <p><input type="checkbox"/> Playmate <input type="checkbox"/> Sexual partners <input type="checkbox"/> Other: _____</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Was the subject a child or employee of a daycare center, nursery, or preschool?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Was the subject a household contact of a child or employee in a daycare center, nursery, or preschool?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. If yes, was there an identified hepatitis A case in the child care facility?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. What is your sexual orientation?
			<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. How many male sex partners have you had?
			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> ≥ 5 <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. How many female sex partners have you had?
			<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> ≥ 5 <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Did the patient inject drugs not prescribed by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Did the patient use street drugs but not inject?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Did the patient travel or live outside of the U.S.A. or Canada?
			a. Where (country)? _____
			b. What was the principal reason for travel?
			<input type="checkbox"/> Business <input type="checkbox"/> New immigrant <input type="checkbox"/> Tourism <input type="checkbox"/> Visiting relatives/friends
			<input type="checkbox"/> Adoption <input type="checkbox"/> Other <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. In the 3 months prior to symptom onset, did anyone in the patient's household travel outside of the U.S.A. or Canada?
			a. If yes, where (country)? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is the patient suspected as being part of a common-source outbreak?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Was the outbreak foodborne – associated with an infected food handler?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Was the outbreak foodborne – not associated with an infected food handler?
			c. Please specify food item if it was a foodborne outbreak: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is subject associated with a waterborne outbreak?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Is subject associated with an outbreak that does not have an identified source?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Was the subject employed as a food handler?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Has the patient ever received the Hepatitis A vaccine?
			a. How many doses? <input type="checkbox"/> 1 <input type="checkbox"/> >2
			b. In what year was the last dose received? ____ (YYYY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Has the subject ever received immune globulin?
			a. When was the last dose received? ____/____/____ (MM/DD/YYYY)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Did the patient experience homelessness in the 2-6 weeks before symptom onset?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Does the patient report incarceration of any duration within 2-6 weeks before symptom onset?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Is the patient co-infected with Hepatitis B?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Is the patient co-infected with Hepatitis C?

Please refer to Section 4 Question 14 above. Was the subject employed as a food handler?
If yes, please continue with the interview on the next page. If not, thank the interviewee for their time and end the interview.

HEPATITIS A SURVEILLANCE FOOD HANDLER FORM

ONLY COMPLETE IF CASE IS A FOOD HANDLER AND ENTER DATA FROM THE COMPLETED CASE REPORT FORM INTO CDRSS

Calculate the Infectious Period

Illness onset date (of jaundice OR elevated liver enzymes) ___ / ___ / _____

INFECTIOUS PERIOD

___ / ___ / _____ TO ___ / ___ / _____

Two weeks before onset date One week after onset date

Complete one form for each food establishment where the infected food handler was employed during the infectious period.

Section 5: Industry and Occupation Information: [Add to the "Industry and Occupation Information" section in CDRSS]			
Yes	No	Unk.	Please answer the following questions as they relate to the period worked when potentially infectious as calculated above
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Work or volunteer as a food handler in the 2 weeks before and 1 week after illness onset?
			Employer Name: _____ Employer Address: _____ Employment Start Date: ___ / ___ / _____ (MM/DD/YYYY) Employment End Date: ___ / ___ / _____ (MM/DD/YYYY) Date last at work: ___ / ___ / _____ (MM/DD/YYYY) Current Occupation (Example: server): _____ Current Industry (Example: cafeteria): _____ Daily duties/tasks: _____ Supervisor: _____ Title: _____ Contact Phone Number: (____) ____ - ____

Ascertain Dates/Shifts Worked

What are the specific dates you worked during the 3 weeks from ___ / ___ / _____ TO ___ / ___ / _____ ?

Two weeks before onset date One week after onset date

WEEK ONE							
Date							
Shift							
WEEK TWO							
Date							
Shift							
Illness Onset Date: ___ / ___ / _____ Shift worked ___ : ___ (AM/PM) to ___ : ___ (AM/PM)							
WEEK THREE							
Date							
Shift							

Section 6: FOOD HANDLING PRACTICES:

Yes	Maybe	No	During the 2 weeks before and 1 week after illness onset, did you:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ever touch food with your bare hands while preparing or serving food?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Handle or prepare food for an event associated with the restaurant, such as a catering event?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prepare or serve food?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Unpack food for storage or for use by another food worker? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Pack food into ice bins for short storage (e.g. shellfish)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Pick or sort fruits or vegetables? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Wash or rinse food items? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Cut, sort, or chop food by hand that will not be cooked (e.g. fruit and vegetables)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Mix ingredients in a container or bowl that will not be cooked (e.g. salad dressings)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Prep food items that were later cooked? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Prep for food items not cooked (e.g. salads, fruits, sandwiches, cheeses, salsa, hummus)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Cook or bake food items? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Prepare/handle ready-to-eat foods (e.g. sandwiches, burritos, salads, ice cream cones)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Bake or reheat food after it was cooked (e.g. pizza slices)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Place baked goods or other ready-to-eat foods on display (e.g. fruits, vegetables, cupcakes, breads)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Place food or desserts onto plates? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Place garnishes on plates (e.g. parsley, fruit)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Place utensils into food (e.g. serving spoon)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Wrap food for takeout? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Wrap or store leftovers for customers or reuse? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Handle food items that were distributed to restaurants or retail stores? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Serve food? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?

Yes	Maybe	No	During the 2 weeks before and 1 week after illness onset, did you:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prepare drinks (e.g. water, soda, mixed drinks)? a. Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Pour beverages or drinks into drinking containers? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Place garnishes on glasses or in drinks (e.g. lemon, lime, cherries, mint)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Place garnishes on glasses or in drinks (e.g. lemon, lime, cherries, mint)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Put ice into glasses? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Use scoop to dispense ice? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Serve drinks? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
Yes	Maybe	No	During the 2 weeks before and 1 week after illness onset, did you:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Handle clean plates, glasses, or other cleaned food utensils? a. Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Wash dishes or utensils? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Prepare utensils for tables (e.g., wrap in napkin)? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Set clean utensils (forks, knives) on the table? a. If yes or maybe, <input type="checkbox"/> Gloves on? <input type="checkbox"/> Gloves off?

Please describe any other duties that you performed during this time:

Section 7: HAND WASHING PRACTICES:

1. How often do you wash your hands with soap and water after using the bathroom?
 Always Sometimes Never Nowhere available to wash

2. Where do you wash your hands at work? *Check all that apply*
 Sink in food prep area Bathroom near food prep area Bathroom in other area Bar sink
 Other: _____ Nowhere available to wash

3. While at work, when do you typically wash your hands? _____

4. Did all the hand washing areas that you used have:
a. Soap: Yes No
b. Warm water: Yes No
c. Paper towels or electric hand dryer: Yes No

Section 8: CONTACT WITH OTHER FOOD HANDLERS: *[Add to the "Contact Tracing" tab in CDRSS]*

Yes	Maybe	No	Do any members of your household or people close to you work in the food industry?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Name: _____ Phone: (____) ____ - ____ Address: _____ Workplace: _____
			b. Name: _____ Phone: (____) ____ - ____ Address: _____ Workplace: _____
			c. Name: _____ Phone: (____) ____ - ____ Address: _____ Workplace: _____

This is the end of the questionnaire.

Thank you very much for your time. These interviews are extremely valuable in helping us understand how and why people are getting sick. Depending on what we find out when we put these interviews together, we may need to talk to you again about a few details.

Would you like to provide any additional thoughts or perspective on exposure activities before illness onset that we may not have covered in the interview?