**PEDIATRIC HEPATITIS OF UNKNOWN ETIOLOGY MEDICAL RECORD ABSTRACTION FORM**

**CaseID: _____**

Form Approved: OMB No. 0920-1011
Exp. Date 01/31/2023

*Version 15 Aug 2022*

**General Instructions:**

Please complete the form for all children who meet the case definition: hepatitis of unknown etiology (with or without adenovirus testing) among children <10 years with aspartate aminotransferase (AST) or alanine aminotransferase (ALT) (>500 U/L) since October 1, 2021.

- Yellow fields do not need to be submitted to CDC.
- CaseID: Please assign using the letter abbreviation for your state/territory followed by a unique ID (can be either a combination of numeric or alpha characters) assigned by your state
- All dates should be in the format MM/DD/YYYY.

**Reminder about adenovirus testing:**

- CDC is recommending adenovirus PCR testing on all specimen types including respiratory, stool, and blood (including whole blood, plasma or serum) specimens.
- CDC requests all residual specimens (adenovirus positive or negative) be submitted to CDC.
- Please refer to the specimen protocol for additional instructions on testing/shipping of specimens. Instructions can be found here: Instructions for Adenovirus Diagnostic Testing, Typing, and Submission | CDC

**Form Submission Instructions:**

CDC requests submission of completed forms on a rolling basis. Please upload completed forms to the ShareFile folder via one of the following:

1. Scanned/electronic copy of the completed form
2. CSV raw data export from REDCap database (if using CDC REDCap data structure in state/local REDCap instance)

For questions related to form completion or submission instructions, email ncirddvdgast@cdc.gov

# PEDIATRIC HEPATITIS OF UNKNOWN ETIOLOGY MEDICAL CHART ABSTRACTION FORM

*Version: 15 Aug 2022* *CASE ID:*_____

**Date form completed:** ____/____/_____ **Date PUI reported to health department**: ____/____/_____

## DEMOGRAPHICS *Yellow fields do not need to be submitted to CDC*

**Patient's name (Last, First, M.I.)** _____ **Street Address:** _____

**City:** _____ **County:** _____ **State:** _____ **Zip:** _____

**DOB:** ____/____/_____ **Age:** _____ □ Days □ Months □ Years **Sex assigned at birth:** □ Male □ Female □ Refused □ Don't know

**Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

**Race (check all that apply)** □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ White □ Other (_____)

## CLINICAL INFORMATION & LABORATORY MARKERS

*Yellow fields do not need to be submitted to CDC. For date of initial evaluation, note date that the child first sought medical care for this illness.*

**Date of initial evaluation (for this illness):** _____/_____/_____ □ Unknown

**Was the patient hospitalized for this illness?** □ Yes □ No □ Unknown *If yes…*

**Admission date (initial hospital)**: ____/____/_____ □ Unknown **Date of discharge / death:** _____/_____/_____ □ Unknown

**Was the patient transferred from another hospital?** □ Yes □ No □ Unknown ***If yes*, which hospital?** _____ **Date Transferred:** ___/___/_____ □ Unknown

**Final patient outcome**: □ Survived, discharge home □ Survived, discharged other location □ Died □ Unknown ***If died,* was an autopsy performed?** □ Yes □ No □ Unknown

**Did patient receive a liver transplant (for this illness)?** □ Yes □ No □ Unknown ***If yes,* which hospital?** _____ **Date of Transplant:** ___/___/_____ □ Unknown

**Is a liver specimen (e.g., biopsy or explant tissue) available?** □ Yes □ No □ Unknown ***If yes,* which specimen type (check all that apply):** □ Biopsy □ Native liver explant

**Alanine aminotransferase (ALT, U/L)** Peak value: _____ **Specimen collection date:** ___/___/_____ □ Unknown

**Aspartate aminotransferase (AST, U/L)** Peak value: _____ **Specimen collection date:** ___/___/_____ □ Unknown

## UNDERLYING HEALTH CONDITIONS

**Did the patient have any underlying health conditions?** □ Yes □ No □ Unknown *If yes, check all that apply:*

□ Chromosomal/Congenital Disorders, specify _____
□ Gastrointestinal/Nutritional Disorders, specify _____
□ Immunosuppressive Therapy, specify _____
□ History of any transplant, specify _____
□ Cancer, specify_____
□ Premature Birth (Gestational age at birth: _____ weeks)
□ Other condition, specify _____

## ADENOVIRUS TESTING

*CDC recommends adenovirus diagnostic testing on all respiratory, stool, and blood specimens. Any residual specimens should be sent to CDC. Report any repeat testing in the 'Other sample, specify' fields and specify the specimen type.*

| Diagnostic Test | Tested/Result | Specimen Collection Date (mm/dd/yyyy) | Is specimen available for shipping to CDC? |
|---|---|---|---|
| Stool | □ Not tested □ Pos □ Neg □ Indeterm □ Pending □ Unknown ***If tested, specify type:*** □ Multipanel PCR □ Other PCR □ Antigen | | □ Yes □ No □ Unknown |
| Respiratory or throat | □ Not tested □ Pos □ Neg □ Indeterm □ Pending □ Unknown ***If tested, specify type:*** □ Multipanel PCR □ Other PCR □ Antigen | | □ Yes □ No □ Unknown |
| Whole blood | □ Not tested □ Pos □ Neg □ Indeterm □ Pending □ Unknown | | □ Yes □ No □ Unknown |
| Plasma | □ Not tested □ Pos □ Neg □ Indeterm □ Pending □ Unknown | | □ Yes □ No □ Unknown |
| Serum | □ Not tested □ Pos □ Neg □ Indeterm □ Pending □ Unknown | | □ Yes □ No □ Unknown |
| Other sample, specify: _____ | □ Not tested □ Pos □ Neg □ Indeterm □ Pending □ Unknown | | □ Yes □ No □ Unknown |

**Was typing performed on any adenovirus positive specimen?** □ Yes □ No □ Unknown **Specimen type:** □ Whole blood □ Plasma □ Serum □ Stool □ Respiratory/throat □ Unknown **Adenovirus type**: _____

**Any other clinically relevant information?**