PEDIATRIC HEPATITIS OF UNKNOWN ETIOLOGY MEDICAL RECORD ABSTRACTION FORM

CaseID: _____

Form Approved: OMB No. 0920-0004
Exp. Date XX/XX/XXXX

Version 11 March 2026

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: 11 March 2026 *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:** □ Male □ Female

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

Race (check all that apply) □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Asian □ White □ Black/African American □ 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 □ Died □ Survived, discharged other location □ 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?