CONFIDENTIAL
FOLLOW-UP OF POSITIVE HEPATITIS C LABORATORY REPORT

PROVIDER INFORMATION: Ordering Provider (as reported by lab):

Primary Care Provider, if known: _____ **Phone:** _____

PATIENT INFORMATION (PLEASE PROVIDE ANY MISSING DEMOGRAPHIC INFORMATION)

Last Name: **First Name:** **MI:** **DOB:**

Please indicate any other name by which patient has been known: _____

Address: **Apt. No.** **City:** **Zip:**

If this is not a new diagnosis, when and where was patient diagnosed previously? _____

PLEASE CIRCLE APPROPRIATE VALUES:

Occupation: Food Service Day Care Health Care Student/School Inmate Correction Work
Disabled Unemployed Other, Specify _____ Unknown

Country of Birth, please specify: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: White Black American Indian/Alaskan Asian
Other, Specify _____ Unknown

Sex: Male Female **Is patient pregnant? If yes, Due Date:** _____ No _____

Please verify diagnosis (refer to case definitions): Acute* Chronic

***PLEASE CALL THE LOCAL HEALTH DEPARTMENT IMMEDIATELY AT 753-5164 TO REPORT ACUTE HEP C**

Is the patient aware of their positive test result? Yes No

PLEASE ANSWER THE FOLLOWING QUESTIONS BASED ON THE CURRENT TEST DATE

ILLNESS AND MEDICAL CARE

Did the patient have a discrete onset of symptoms at the time of diagnosis? No Yes If yes, onset date: _____

Symptoms: Fever Headache Malaise Anorexia Nausea Vomiting Diarrhea
Abdominal Pain Other, please specify: _____

Was patient jaundiced at time of first reported positive test result? No Yes If yes, onset date: _____

REASON FOR HCV TESTING (CHECK ALL THAT APPLY)

___ Symptoms of Hepatitis
___ Asymptomatic patient with reported risk factors
___ Asymptomatic patient with no reported risk factors
___ History of Hepatitis C
___ Evaluation of elevated liver enzymes
___ Blood/organ donor screening
___ Age Based (CDC recommendations)
___ Other, please specify _____

POTENTIAL SOURCES OF EXPOSURE/RISK FACTORS

Contact of person with Hep C? Yes No Unknown

If yes, type of contact (indicate all that apply):

Household (non-sexual) Yes No Unknown

Sexual Yes No Unknown

IV drug use partner Yes No Unknown

Other, specify: _____

Receive blood transfusion prior to 1992 Yes No Unknown

Receive organ transplant prior to 1992 Yes No Unknown

Receive clotting factor concentrate produced prior to 1987 Yes No Unknown

Ever on long-term hemodialysis Yes No Unknown

Ever employed in a medical or dental field involving direct contact with human blood Yes No Unknown

Is the patient diabetic Yes No Unknown

Number of lifetime male sex partners did the patient have? 0 1 2-5 >5 Unknown

Number of lifetime female sex partners did the patient have? 0 1 2-5 >5 Unknown

Ever inject drugs not prescribed by a doctor (even if only once) Yes No Unknown

Ever use street drugs, but not inject? Yes No Unknown

Ever incarcerated Yes No Unknown

Ever treated for sexually transmitted disease (STD)? Yes No Unknown

Did the patient have any PRIOR NEGATIVE anti-HCV tests within the last 6 months? Yes No Unknown

If Yes: Date of test: _____

Vaccine History

Ever receive Hepatitis A vaccine Yes No Unknown If yes, how many doses: ____ Date of last dose: _____

Ever receive Hepatitis B vaccine Yes No Unknown If yes, how many doses: ____ Date of last dose: _____

Counseling Information

Is patient currently being monitored by a health care provider for Hepatitis C infection Yes No Unknown

Did the patient ever receive treatment for Hepatitis C Yes No Unknown

Was the patient provided education/counseling regarding Hepatitis C infection by Physician? Yes No Unknown

OR

By Local Health Department Yes No Unknown

By NYS DOH Yes No Unknown

No Counseling Yes No Unknown

Other, please specify: _____

Individual completing form: _____ **Title:** _____ **Date:** _____