New Hampshire Confidential Hepatitis C Provider Reporting Form

NH DIVISION OF Public Health Services
Department of Health and Human Services

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____/_____/_____

Address: _____ ☐ **No fixed address**

City/State/Zip: _____ **Phone:** _____

Pronouns: _____ **Primary Language:** _____ **Is the patient pregnant?** ☐ **Yes** ☐ **No** ☐ **Unknown**

Sex Assigned at Birth
☐ Male ☐ Female

Gender Identity
☐ Male ☐ Female ☐ Trans male
☐ Trans female ☐ Other: _____

Race
☐ White ☐ Black ☐ Asian ☐ Pacific Islander
☐ American Indian ☐ Alaskan Native
☐ Other: _____ ☐ Unknown

Ethnicity
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Occupation/Employment
_____

Country of Birth
☐ United States
☐ Other: _____

Is this the first time this patient has ever been diagnosed with hepatitis C infection? ☐ Yes ☐ No

Diagnosis date: _____/_____/_____
Symptom onset date: ____/____/____

Is the patient aware of the diagnosis? ☐ Yes ☐ No
☐ Asymptomatic ☐ Jaundice ☐ Other: _____

Test Type	Test Date	Result
☐ HCV antibody (anti-HCV)	_____/_____/_____	☐ Positive ☐ Negative
☐ Viral detection (NAT/PCR for HCV RNA)	_____/_____/_____	☐ Positive ☐ Negative
☐ HCV viral antigen	_____/_____/_____	☐ Positive ☐ Negative
☐ HCV genotype	_____/_____/_____	_____
☐ Peak total bilirubin	_____/_____/_____	_____mg/dL
☐ Peak serum alanine aminotransferase (ALT)	_____/_____/_____	_____IU/L

Does the patient have another diagnosis which more likely explains their symptoms and/or liver function? ☐ Yes ☐ No
Did the patient have a negative HCV test within the 12 months prior to first positive result? ☐ Yes ☐ No

Treatment status: ☐ Treatment complete ☐ Referred for follow-up care ☐ Diagnosing provider will treat ☐ Infection cleared

☐ No treatment plan at this time ☐ Other:_____

Contextual Factors (check all that apply)

Injection drug use	☐ Within 6 months ☐ Lifetime ☐ Denies ☐ Unknown
Non-injection illicit drug use	☐ Within 6 months ☐ Lifetime ☐ Denies ☐ Unknown
Incarceration	☐ Current ☐ Ever ☐ Never ☐ Unknown
Occupational exposure to blood	☐ Yes ☐ No ☐ Unknown
Tattoo (prison, home, or non-professional)	☐ Yes ☐ No ☐ Unknown
Long-term hemodialysis	☐ Yes ☐ No ☐ Unknown
Blood transfusion prior to 1992	☐ Yes ☐ No ☐ Unknown
Organ transplant prior to 1992	☐ Yes ☐ No ☐ Unknown
Clotting factor concentrates prior to 1987	☐ Yes ☐ No ☐ Unknown
Household contact to person with HCV	☐ Yes ☐ No ☐ Unknown
Sexual contact to person with HCV	☐ Yes ☐ No ☐ Unknown

Has the patient ever had sexual contact with (check all that apply): ☐ Men ☐ Women ☐ Transgender persons

Date of last HIV test: _____/_____/_____ ☐ Positive ☐ Negative

Diagnosing Provider: _____ **Facility:** _____ **City/State:**_____

Person Reporting: _____ **Phone:** _____ **Date:** _____/_____/_____ ***Version 10/2022***

Fax completed forms to: 603-696-3017 **Additional Forms available at: http://bit.ly/NH_Inf_Dis_Reporting**

NH RSA 141-C and He-P300 mandates reporting of viral hepatitis C, newly diagnosed infections only, all physicians and health care providers. We request prompt reporting of suspect and confirmed cases within 72 hours of diagnosis. All reports are handled under strict confidentiality standards.