



**New Hampshire Confidential
Hepatitis C Provider Case Report Form** v2 Nov2018
(New Diagnoses Only)

Date of Report: ___/___/___

Hepatitis C Being Reported: Acute Chronic Cleared (not active) Infection Unknown

Patient Information

Name _____
(Last) (First) (M.I.)

Date of Birth ___/___/___ Age _____ Sex: Male Female Other

Address _____ City/Town _____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

Occupation/Employment _____

Miscellaneous: Healthcare Worker Long-term Care Resident Pregnant # of weeks: _____

Race: White Black Asian Pacific Islander Native Am./Alaskan Nat Unknown Other: _____

Ethnicity: Hispanic Not Hispanic Unknown

Country of Birth: United States Other (specify) _____ Unknown

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

Diagnosis Date: ___/___/___ Is patient aware of diagnosis? Yes No Unknown

Symptoms

Asymptomatic (no symptoms) Symptomatic Symptom Onset Date: ___/___/___
 Fever Malaise Nausea Abdominal Pain Diarrhea
 Headache Anorexia Vomiting Jaundice Other: _____

Hepatitis C (HCV) Testing

Tests Performed	Positive	Negative	Not Done	Unknown	Date
<input type="checkbox"/> Antibody Test (anti-HCV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
<input type="checkbox"/> Supplemental anti-HCV assay (RIBA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
<input type="checkbox"/> HCV Rapid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
<input type="checkbox"/> HCV RNA/PCR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
<input type="checkbox"/> HCV Antigen (approval pending)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___
<input type="checkbox"/> HCV Genotype: _____			<input type="checkbox"/>	<input type="checkbox"/>	___/___/___

Liver Enzyme Levels: ALT/SPGT: _____ AST/GOT: _____ Not done Unknown

Does the patient have a negative HCV test result within the last 12 months? Yes No Unknown

Risk Factors/Reason for Testing (check all that apply)

- Year of birth 1945-1965 (i.e. "baby boomer") Yes No Not asked Unknown
- Tattoo (prison, home or non-professional) Yes No Not asked Unknown
- Employed in medical/dental/public safety or other field Yes No Not asked Unknown
involving direct contact with blood
- Incarceration Yes No Not asked Unknown
- Non-injection illicit drug use Yes No Not asked Unknown
- Injection drug use, ever, even if only one time Yes No Not asked Unknown
- Injection drug use, currently using or within last 6 months Yes No Not asked Unknown
- Long term hemodialysis Yes No Not asked Unknown
- Blood transfusion prior to 1992 Yes No Not asked Unknown
- Organ transplant prior to 1992 Yes No Not asked Unknown
- Clotting factor concentrates produced prior to 1987 Yes No Not asked Unknown
- Household contact of a person who had hepatitis C Yes No Not asked Unknown
- Sexual contact with a person who had hepatitis C Yes No Not asked Unknown

Has the patient ever had sexual contact with (check all that apply):

- Males Females Transgendered Unknown

If no risk factors listed above:

Has patient had a medical procedure (e.g. surgery, colonoscopy, etc.) or hospital stay within the last 6 months?

- Yes No Unknown

If yes, Type: _____ Location: _____ Date: ____/____/____

Health Care Provider Referral Information

Has this patient been referred to another healthcare provider for follow-up care? Yes No Unknown

If yes, what type of specialist: Infectious Disease Gastroenterologist Other: _____

Referral Provider Name _____ Phone _____

Referral Provider Facility/Practice Name _____

City/Town _____ State _____ Zip _____

Health Care Provider Reporting Information

Person Completing Report Form _____

Ordering Provider _____ Phone _____

Provider Facility/Practice Name _____

City/Town _____ State _____ Zip _____

Fax to: (603) 271-0545

NH Department of Health and Human Services

Bureau of Infectious Disease Control

Office Phone: 603-271-4496

For NH DHHS Use Only

Acute: Confirmed Probable

Chronic: Confirmed Probable

Cleared Infection

Unknown

Not a case of any type of hepatitis C

Entered in NHEdSS Assigned to Investigator