NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

New Hampshire Confidential Hepatitis C Provider Case Report Form v2 Feb2017

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 <u>first</u> 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 ☐ Jaundice ☐ Other: _____

Hepatitis C (HCV) Testing

Tests Performed	Positive	Negative	Unknown	Date
☐ Antibody Test (anti-HCV)	☐	☐	☐	____/_____/_____
☐ Supplemental anti-HCV assay (RIBA)	☐	☐	☐	____/_____/_____
☐ HCV Rapid	☐	☐	☐	____/_____/_____
☐ HCV RNA/PCR	☐	☐	☐	____/_____/_____
☐ HCV Antigen (development and approval pending)	☐	☐	☐	____/_____/_____
☐ HCV Genotype: _____			☐	____/_____/_____

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

Does the patient have a <u>negative</u> HCV test result within the last 12 months? ☐ Yes ☐ No ☐ Unknown

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

Blood transfusion prior to 1992	☐ Yes	☐ No	☐ Unknown
Organ transplant prior to 1992	☐ Yes	☐ No	☐ Unknown
Clotting factor concentrates produced prior to 1987	☐ Yes	☐ No	☐ Unknown
Long term hemodialysis	☐ Yes	☐ No	☐ Unknown
Injection drug use, ever, even if only one time	☐ Yes	☐ No	☐ Unknown
Injection drug use, currently using or within the last 6 months	☐ Yes	☐ No	☐ Unknown
Non-injection illicit drug use	☐ Yes	☐ No	☐ Unknown
Incarceration	☐ Yes	☐ No	☐ Unknown
Employed in medical/dental/public safety or other field involving direct contact with blood	☐ Yes	☐ No	☐ Unknown
Tattoo (prison, home or non-professional)	☐ Yes	☐ No	☐ Unknown
Year of birth 1945-1965 (i.e. "baby boomer")	☐ Yes	☐ No	☐ Unknown
Household contact of a person who had hepatitis C	☐ Yes	☐ No	☐ Unknown
Sexual contact with a person who had hepatitis C	☐ Yes	☐ No	☐ 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**