New Hampshire Confidential
Hepatitis C Provider Reporting Form

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: _____/_____/_____ Is the patient aware of the diagnosis? ☐ Yes ☐ No

Symptom onset date: ____/____/____ ☐ 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 06/2024***

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.