New Hampshire Confidential
Hepatitis C Provider Case Report Form
(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 _______________________________   Healthcare Worker: ☐ Yes ☐ No ☐ Unknown
Is the patient a resident of a long-term care facility? ☐ Yes ☐ No ☐ Unknown
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 the patient pregnant? ☐ Yes ☐ No ☐ Unknown If yes, # of weeks: ______  Due Date: __/__/____

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
☐ Antibody Test (anti-HCV)  ☐ ☐ ☐ ☐ __/__/_______
☐ Supplemental anti-HCV assay (RIBA)  ☐ ☐ ☐ ☐ __/__/_______
☐ HCV Rapid  ☐ ☐ ☐ ☐ __/__/_______
☐ HCV RNA/PCR  ☐ ☐ ☐ ☐ __/__/_______
☐ HCV Antigen (approval pending)  ☐ ☐ ☐ ☐ __/__/_______
☐ HCV Genotype: __________________________  ☐ ☐ ☐ ☐ __/__/_______

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
**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 ________________

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**Health Care Provider Reporting Information**

Person Completing Report Form ____________________________

Ordering Provider ____________________________  Phone ________________________

Provider Facility/Practice Name ____________________________________________

City/Town __________________________ State ________ Zip ________________

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Fax to: (603) 696-3017  
NH Department of Health and Human Services  
Bureau of Infectious Disease Control  
Office Phone: (603) 271-4496  

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**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 involving direct contact with blood | ☐ Yes  ☐ No  ☐ Not asked  ☐ Unknown |
| 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  ☐ Transgender  ☐ 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: ___/___/____

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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