



PATIENT INFORMATION

Hepatitis C – Chronic, long

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex F M Other Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE – LHJ USE

Investigator _____
 LHJ notification date ___/___/___
 LHJ case classification Confirmed Probable Suspect Not a case State case Contact Control Exposure
 Not classified
 Investigation status Investigation not started In progress Complete Complete - not reportable to DOH
 Unable to complete
 Investigation start date ___/___/___
 LHJ investigation complete date ___/___/___
 LHJ record complete date ___/___/___
 Outbreak related Yes No Unknown
 LHJ cluster name _____ LHJ cluster number _____

DEMOGRAPHICS

Current gender Male Female Other Declined to answer Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?
 Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses).
 Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American
 Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:
 Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____

Country of birth _____

What is your (your child's) preferred language (check one):
 Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Employed Yes No Unknown
 If yes, Occupation _____ Employer/worksite _____ Zip code (occupation) _____

Student (including in daycare) Yes No Unknown
 If yes, School/childcare _____ Grade _____ Zip code (school) _____

REPORT SOURCE(S)

Report source _____
 Report date ___/___/___
 Reporter name _____
 Reporter organization _____
 Reporter phone _____

Diagnosis at state correctional facility Yes No Unknown

If yes, Diagnosis type Acute Chronic

COMMUNICATIONS – LHJ USE (Please document all attempts to gather information, including patient interview, provider outreach, or medical record abstraction)

Contact attempted Yes No
 Date of contact attempt ___/___/___
 Contact attempt type Phone call to patient Phone call to medical provider Medical record search Text to patient
 Letter to patient E-mail to patient Patient's social media Other _____
 Contact attempt outcome Unable to contact Contacted and interviewed Contacted and scheduled
 Successful medical record review Left message Pending response Reinterviewed

Interviewer _____

Was patient acute, chronic, or perinatal at time of contact attempt? Unknown

Notes:

ALTERNATIVE INFORMATION SOURCE

Type Friend Parent/guardian Spouse/partner Other _____
 Name _____
 Phone number _____
 Email address _____

CLINICAL EVALUATION

Chronic diagnosis date ___/___/___

Chronic – Reason(s) for Initial Screening (select all that apply)

- Symptoms of acute hepatitis (vomiting, diarrhea, abdominal pain, anorexia, nausea, or fever)
- Asymptomatic with risk factors Asymptomatic without risk factors Prenatal screening
- Follow-up testing for previous marker of viral hepatitis Blood/organ donor screening Elevated liver enzymes
- High risk exposure Other _____

Setting of initial screening Primary care clinic ID/GI/liver clinic OB/GYN clinic Emergency room/urgent care
 Hospital Rehab facility Syringe exchange Jail/prison Non-clinical community site Other _____

INSURANCE AND LINKAGE TO CARE

Insurance status date ___/___/___

Y N Unk

Patient has insurance

Type of insurance (select all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Medicare
Plan ID _____ | <input type="checkbox"/> Medicaid
Plan ID _____ | <input type="checkbox"/> VA/military
Plan ID _____ |
| <input type="checkbox"/> Employer
Plan ID _____ | <input type="checkbox"/> Individual
Plan ID _____ | <input type="checkbox"/> Other _____
Plan ID _____ |

Was patient referred for care?

If yes, Patient seen or has appointment for medical management of HCV

Primary care provider Yes No Specialist Yes No Date of last appointment ___/___/___

If no, Primary reason Incarcerated Patient declined, due to financial barriers (e.g. no insurance)

Patient declined, perceived as unnecessary Appropriate provider not known

Appropriate provider known, inaccessible to patient Unknown Other _____

Y N Unk

Did the patient receive medication for the type of hepatitis being reported?

If yes (patient did receive medication),

Medication name	Dose	Dose units (g, mg, ml)	Freq. per day	Other freq. unit	Duration	Duration unit (days, weeks, months)	Start date	Treatment completed	Completion date
								<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/> In progress	
								<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/> In progress	
								<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk <input type="checkbox"/> In progress	

If Treatment not completed, specify reason Patient financial barriers Lost to follow-up

Patient concerns about safety/adverse effects Other _____

If no (patient did not receive medication), Was treatment recommended but not started

If yes (treatment recommended but not started), Reason not started Appropriate provider not known

Appropriate provider known, inaccessible to patient Patient concerns about safety/adverse effects

Patient financial barriers Patient perceives as unnecessary Treatment prescribed, set to begin

Other _____

Achieved sustained virological response (SVR)

SVR post-treatment time point 12 weeks 24 weeks Other _____

VACCINATION HISTORY

Washington Immunization Information System (WA IIS) number _____

Documented immunity to hepatitis A (due to either vaccination or previous infection)

Yes – vaccination Yes – previous infection No Unk

Number of doses of HAV vaccine in past 0 1 2 3 4 or more Unknown

Documented immunity to hepatitis B (due to either vaccination or previous infection)

Yes – vaccination Yes – previous infection No Unk

Number of doses of HBV vaccine in past 0 1 2 3 4 or more Unknown

COMORBIDITIES AND SCREENING

Y N Unk

Patient ever tested for HBV Date last test ___/___/___ Result Positive Negative Indeterminate Unknown

Patient ever tested for HIV Date last test ___/___/___ Result Positive Negative Indeterminate Unknown

Diabetes Diagnosis date ___/___/___

Cirrhosis Diagnosis date ___/___/___

Decompensated cirrhosis Diagnosis date ___/___/___

Ever diagnosed with liver cancer Diagnosis date ___/___/___

Liver transplant Diagnosis date ___/___/___

Renal dialysis Diagnosis date ___/___/___

Chronic kidney disease Diagnosis date ___/___/___

LIVER STAGING

Y N Unk

Patient ever staged

Staging method APRI score ARFI Biopsy Fib-4 FibroSURE Imaging (e.g. ultrasound, CT, MRI)

Liver elastography (fibrosan) Other _____

Date procedure was completed ___/___/___

Location (i.e. name of facility where procedure was performed) _____

Fibrosis stage _____

Results/notes: _____

PREGNANCY (at time of report)

Pregnant Yes No Unknown

Date that the individual was assessed for pregnancy ___/___/___

If pregnant,

Subtype at time of this pregnancy Acute Chronic Unknown

Estimated delivery date ___/___/___

LABORATORY DIAGNOSTICS (Positive, Negative, Not tested, Indeterminate)**P N NT I**

Antibody to hepatitis C virus (anti-HCV) Signal to cut-off ratio _____
 Specimen collection date ___/___/___ Specimen accession # _____
 Test laboratory _____ Test provider/facility _____

HCV RNA quantitative _____ Quantitative units I.U. I.U., log RNA copies RNA copies, log
 Qualitative interpretation of quantitative result _____
 Specimen collection date ___/___/___ Specimen accession # _____
 Test laboratory _____ Test provider/facility _____

HCV RNA qualitative _____
 Specimen collection date ___/___/___ Specimen accession # _____
 Test laboratory _____ Test provider/facility _____

HCV genotype _____
 Specimen collection date ___/___/___ Specimen accession # _____
 Test laboratory _____ Test provider/facility _____

Liver Enzyme Tests

ALT (SGPT) Specimen collection date ___/___/___ Actual value _____
 AST (SGOT) Specimen collection date ___/___/___ Actual value _____
 BIL (Total) Specimen collection date ___/___/___ Actual value _____

HOSPITALIZATION AND DEATH

Hospitalized at least overnight for this illness Yes No Unknown
 Hospital – facility name _____
 Admitted date ___/___/___ Discharged date ___/___/___ Length of stay _____ days
 Hospital record number _____

If deceased, please change the vital status and update date of death on the Edit Person screen

Deceased Yes No
 Date of death ___/___/___
 Cause of death Hepatitis related Other _____

CHRONIC EXPOSURES (If not otherwise specified report exposure information over the lifetime)**Y N Unk**

Received clotting factor concentrates When Before 1987 1987 or later
 Received blood products When Before 1992 1992 or later
 Received solid organ transplant When Before 1992 1992 or later
 Other organ or tissue transplant recipient Date ___/___/___
 Long term hemodialysis
 Employed in job with potential for exposure to human blood or bodily fluids
 Job type Medical Dental Public safety (e.g. law enforcement/firefighter) Tattoo/piercing Other _____
 Frequency of direct blood or body fluids Frequent (several times a week) Infrequent Unknown

Accidental stick or puncture with sharps contaminated with blood or body fluid
 History of occupational needle stick or splash
 Ever had a finger stick/prick blood sugar test
 Ear or body piercing
 Body site _____ Address/name _____
 Body piercing was performed at Commercial parlor/shop Correctional facility Other _____

Tattoo recipient
 Tattoo was performed at Commercial parlor/shop Correctional facility Other _____

Ever received acupuncture
 History of incarceration
 Birth mother has history of hepatitis C infection
 Born outside US
 Country _____ Number of years in US _____

Contact with confirmed or suspected hepatitis C case (acute or chronic)
 Type of contact Sexual Household (non-sexual) Needle use Birth Casual contact Other _____

Approximate number of lifetime sex partners 0 1 2-5 6-10 11-20 >20 Unknown
 Gender of sex partners Male - Number _____ Female (Number _____) Transgender (Number _____)

Received treatment for an STD
 Year of most recent STD treatment _____

Y N Unk

- Ever injected drugs not prescribed by a doctor, even if only once or a few times
 Injection drug use type (check all that apply) Heroin (includes Diacetylmorphine) Cocaine Amphetamine
 Methamphetamine MDMA Ketamine PCP Opioids (RX or non-RX) Anabolic steroids
 Unknown Other _____
- Ever shared needles Yes No Unknown
- Ever shared other injection equipment Yes _____ No Unknown
- Ever used needle exchange services Yes No Unknown
- Non-injection street drug use/use street drugs
 Specify drug(s) _____
 Route of administration Inhalation Oral Transdermal Other _____
- Used drugs not prescribed by a doctor and route of administration is unknown
 Type (check all that apply) Heroin (includes Diacetylmorphine) Cocaine Amphetamine Methamphetamine
 MDMA Ketamine PCP Opioids (prescription or non-prescription) Anabolic steroids Unknown
 Other _____
- Patient used injection drugs in the past 3 months

EXPOSURE SUMMARY – populate Most likely exposure even if unknown

- Most likely exposure Acupuncture Blood product Body piercing (except ears) Chronic hemodialysis Close contact
- Clotting factor Incarceration Injection drug use In job with potential blood or body fluid exposure
 New or risk sexual partner Organ transplant Perinatal transmission Tattoo Multiple risk factors
 Unknown Other _____

Where did exposure probably occur In USA but not in Washington - State _____ In Washington – County _____
 Not in USA - Country _____ Unknown

Exposure location name _____
 Exposure location address _____
 Exposure location details:

PUBLIC HEALTH ISSUES

Y N Unk

- Patient aware of hepatitis support agencies (e.g. Hepatitis Education Project)
- Recent blood products, organs or tissue (including ova or semen) donation

PUBLIC HEALTH ACTIONS

Y N Unk

- Recommended confirmatory testing
- Counseled on importance of regular healthcare to monitor liver health
- Counseled on avoidance of liver toxins (e.g. alcohol)
- Recommend hepatitis A vaccination
- Recommend hepatitis B vaccination
- Counseled on measure to avoid transmission
- Counseled to not donate blood products, organs or tissues
- Notified blood or tissue bank (if recent donation)
- Counseled about transmission risk to baby if pregnant
- Reinforced use of universal precautions, if health care worker
- Counseled on harm reduction and places to access clean syringes, if current IDU
- Provided contact information for hepatitis support agencies
- Provided patient education materials about HCV
- Provided options for access to health care
- Provided information on alcohol/substance abuse treatment
- Other public health action _____

CONTACTS

Y N Unk

Evaluated contacts

OPTIONAL LHJ USE - DATA ENTRY IN WDRS IS OPTIONAL FOR THIS SECTION

	Contact 1	Contact 2	Contact 3	Contact 4
Date contact identified				
Contact's first name				
Contact's last name				
Contact's date of birth				
Contact's age (DOB unk)	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days	<input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Days
Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Transgender – unspec. <input type="checkbox"/> Declined <input type="checkbox"/> Unk <input type="checkbox"/> Other
Contact's phone				
Contact type (select one)	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Needle use <input type="checkbox"/> Birth <input type="checkbox"/> Casual contact <input type="checkbox"/> Other
OK to talk with this contact:	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__	<input type="checkbox"/> Yes <input type="checkbox"/> Never <input type="checkbox"/> Unk <input type="checkbox"/> Later – date __/__/__
Method of contact (select one)	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR	<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> In-person <input type="checkbox"/> Mail <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Accessed EMR
Contact interview date				
Referred to PCP for evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Note				

(NOT REQUIRED) HCV CONTINUUM OF CARE – LHJ USE

Stage on the HCV continuum (select all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> HCV antibody positive
Antibody date: __/__/__ | <input type="checkbox"/> Not an HCV case (RNA negative)
RNA negative date: __/__/__ | <input type="checkbox"/> HCV confirmed (RNA positive)
RNA positive date: __/__/__ |
| <input type="checkbox"/> Linked to HCV care
Linked to care date: __/__/__ | <input type="checkbox"/> HCV treatment
Treatment date: __/__/__ | <input type="checkbox"/> Cured/SVR
Cured date: __/__/__ |

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