



Hepatitis C – Chronic, short

County _____

PATIENT INFORMATION

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

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: _____

CHRONIC EVENT ADMINISTRATION – LHJ USE

LHJ notification date ___/___/___
 Investigator _____
 Investigation start date ___/___/___

DEMOGRAPHICS

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: _____

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

CLINICAL EVALUATION

Chronic diagnosis date ___/___/___

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

Y N Unk

- 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 reason for testing _____

Settings 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 _____

PREGNANCY

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 _____

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
- Birth mother has history of hepatitis C infection
- 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 contact w/ 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 _____
- Ever received acupuncture
- Tattoo recipient
 Tattoo was performed at Commercial parlor/shop Correctional facility Other _____

Y N Unk

History of incarceration
 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 _____
 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 (prescription or non-prescription) 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
 Patient used injection drugs in the past 3 months

Most likely exposure (select one) 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 _____

DEATH

If deceased, please change the vital status and update date of death on the Edit Person screen
Deceased Yes No
Date of death ___/___/___ Source used to verify vital status Death records Medical records Other _____
Death document ID _____

ADMINISTRATIVE – LHJ USE

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
LHJ investigation complete date ___/___/___
LHJ record complete date ___/___/___

(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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