Leeds, Grenville & Lanark District HEALTH UNIT

HEPATITIS C REPORTING FORM
EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

REPORTING SOURCE

Name:	Agency:	
Phone #:	Date (y/m/d):	Time:

CLIENT INFORMATION

Last Name:	First Name:	Gender:
Phone #:	DOB (y/m/d):	
Address:	City:	Postal Code:
HEALTH CARE PROVIDER:	Phone #:	Fax #:

MEDICAL RISK FACTORS (please check all that apply)

☐ Received blood or blood products: Year: | Country:

☐ Dialysis recipient: Province/Country:

☐ Pregnant | ☐ Born to case/carrier | ☐ Born in endemic country (specify):

☐ HIV status: | ☐ Repeat STI

☐ Invasive dental, tissue, transplant, procedures (specify):

Date: Location:

☐ Invasive medical, surgical procedures (specify, i.e. colonoscopy):

Date: Location:

BEHAVIOURAL SOCIAL RISK FACTORS (please check all that apply)

☐ Inhalation drug use	☐ Tattoo	☐ Contact is Hep C +	☐ Correctional facility
☐ Injection drug use	☐ Piercing	☐ Contact is HIV +	☐ Exposure to potential
☐ Intranasal use	☐ Electrolysis	☐ High-risk sexual activity	Hep C body fluids (fighting/accident)
☐ Shared drug equipment	☐ Acupuncture	☐ Sex with opposite sex	☐ Occupational exposure
☐ Homeless/under-housed	☐ Other personal services	☐ Sex worker	☐ Unknown
☐ Shared personal items		☐ Sex with same sex	

CASE DETAILS

Date of Diagnosis (y/m/d):

SYMPTOMS: ☐ Asymptomatic Earliest Onset Date (*except in an asymptomatic case*):

☐ Abdominal pain	☐ Nausea/vomiting	☐ Loss of appetite/weight	☐ Dark Urine
☐ Malaise/Fatigue	☐ Jaundice	☐ Generalized body aches	☐ Other:

CASE FOLLOW-UP (Refer to Health Care Provider Counselling Guidelines *for Hepatitis C Positive Individuals* attached)

Is patient aware of Hepatitis C status? ☐ Yes ☐ No | Has HCV-RNA testing been done? ☐ Yes ☐ No

Has patient been referred to a liver specialist? ☐ Yes ☐ No

Have you provided counselling, including:

☐ Eligibility for free Hepatitis A , Hepatitis B, and pneu-P-23 vaccines

☐ HCV Transmission ☐ Ways to stay healthy ☐ Contact notification for newly infected patients

Would you like a Public Health Nurse to provide further information to your patient? ☐ Yes ☐ No

NOTE: For more information on the management of Hepatitis C, including RNA testing, vaccine order form and further resources, please visit our REPORTABLE DISEASES TOOLKIT available on our website.

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7.

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FOR HEALTH UNIT USE ONLY				
NOTES (Response/Assessment/Intervention/Plan)			**INVESTIGATOR:**	
			iPHIS Client #:	
DATE	**TIME**		**iPHIS Case/Incident #:**	
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
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