Services de santé du TIMISKAMING Health Unit

Hepatitis B/C Reporting Form

All information below is required.
Please complete and fax to THU 705-647-5779

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 #:

RISK FACTORS (Check all that apply) ****Specify where acquired if known****

Medical Risk Factors:

☐ 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

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

MEDICAL DETAILS

Date of Diagnosis (y/m/d):

Symptoms:	**Onset date (y/m/d)**	**Symptoms:**	**Onset date (y/m/d)**
☐ Asymptomatic		☐ Elevated liver enzymes	
☐ Right-sided abdominal discomfort		☐ Malaise	
☐ Anorexia		☐ Nausea	
☐ Easily bruised or bleeding		☐ Rash	
☐ Fatigue		☐ Dark urine	
☐ Fever		☐ Vomiting	
☐ Jaundice		☐ Other, specify:	

CASE FOLLOW-UP

Is patient aware of Hepatitis B/C status? ☐ Yes ☐ No

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

Has the patient received Hep A, Hep B and Pneumo23 vaccinations? ☐ Yes ☐ No
Patient may qualify for high risk vaccinations (publicly funded schedule), for more info contact THU*

If previously vaccinated, please include dates:

Hepatitis A	Date:	Date:	
Hepatitis B	Date:	Date:	Date:
Pneumo23	Date:		

Do you require any assistance with the following (please check all that apply):

Counselling/testing recommendations:
- ☐ HCV RNA
- ☐ HIV
- ☐ HBV
- ☐ STIs

Discuss
- ☐ Contact follow-up
- ☐ HBV, HAV and Pneumo 23 imm

Education/counselling
- ☐ Harm reduction services
- ☐ Risk of transmission to others (including during pregnancy) and how to mitigate
- ☐ Discussed treatment
- ☐ Referral to specialist
- ☐ Healthy living with HCV

Comments:

CONTACT INFORMATION (copy as many as needed)

Contact Notification:
- ☐ Public Health Unit
- ☐ Case
- ☐ Provider

Contact Name: _____

DOB: _____ or Age: _____

Address: _____

Phone: _____

Email: _____

Contact Type:
- ☐ Shared drug equipment
- ☐ Sexual exposure
- ☐ Blood exposure specify:

Comments: