DEPARTMENT OF HEALTH and SOCIAL SERVICES
Division of Public Health
Hepatitis C Case Report

Patient & Demographic Data

Patient Name:	Last:	First:	Middle:
Address:		State:	Zip:
Telephone #:		Date of Birth: ____/____/____	
Sex:	☐ Male ☐ Female	Birthplace: ☐ USA ☐ Other Specify_____	
Pregnancy:	Yes _____ No _____	EDC _____	
Race:	☐ American Indian or Alaskan Native	☐ Native Hawaiian/Pacific Islander	Ethnicity: ☐ Hispanic
	☐ Asian	☐ White	☐ Non- Hispanic
	☐ Black or African American	☐ Other Specify _____	☐ Unknown

Clinical & Diagnostic Data

Reason for Test	☐ Screening ☐ Medical	Test date: ____/____/____	

Signs and Symptoms				Lab Results		
	Yes	No	Onset Date	Test	Value	Date
Jaundice	☐	☐	____/____/____	Liver Function Test		
Abdominal Pain	☐	☐	____/____/____	ALT		____/____/____
Fever	☐	☐	____/____/____	AST		____/____/____
Headache	☐	☐	____/____/____	Bilirubin		____/____/____
Anorexia	☐	☐	____/____/____	HCV Diagnosis and Genotyping		
Malaise	☐	☐	____/____/____	HCV Antibody		____/____/____
Nausea	☐	☐	____/____/____	HCV RNA/Viral Load		____/____/____
Vomiting	☐	☐	____/____/____	HCV Genotype		____/____/____
Diarrhea	☐	☐	____/____/____			

Is there evidence of a negative HCV Antibody Test in the last 12 months?	☐ Yes ☐ No Date Of Test: ____/____/____	Fibrosis score present? ☐ Yes ☐ No Score: ☐ 0 ☐ 1 ☐ 2 ☐3 ☐ 4	Date: ____/____/____

Risk Factors

	Yes	No	Unknown
Received a blood transfusion prior to 1992	☐	☐	☐
Received an organ transplant prior to 1992	☐	☐	☐
Received clotting factor before 1987	☐	☐	☐
Ever been on long term hemodialysis	☐	☐	☐
Identifies as MSM	☐	☐	☐
Has History of illicit drug use	☐	☐	☐
Ever injected illicit drugs	☐	☐	☐
Is HIV positive	☐	☐	☐

Treatment

Does patient have health insurance? ☐ Yes ☐ No ☐ Unknown	Insurance Source :	☐ Medicaid	☐ Medicare
		☐ Private	☐ Tricare

Testing Providers name:	Providers Specialty:	
Phone#:	Fax #	Email:
Name of Practice:		
Address:	City: State:	Zip:

Was patient referred for Care? ☐ Yes ☐ No ☐ Unknown	***If patient was referred, please provide contact information below***		
Treating Provider Name:			
Phone#:	Fax #	Email:	
Name of Practice:			
Address:	City: State:	Zip:	

Please provide all treatment information below to the best of your ability:

Prescription #1_____	☐ Currently taking	☐ Completed	Date Completed: ____/____/____
Prescription #2_____	☐ Currently taking	☐ Completed	Date Completed: ____/____/____
Prescription #3_____	☐ Currently taking	☐ Completed	Date Completed: ____/____/____

Printed name of person completing form: _____ Date of form completion: ____/____/____

*PLEASE RETURN COMPLETED FORM TO FAX# (302)622-4409 or Email to: DPH_ViralHepatitis@state.de.us Revised June 19, 2018