Hepatitis C Virus (HCV) – Positive Report

1230 Talbot Street
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www.elginhealth.on.ca

Client Information

Name: ______________________________________ Date of Birth: _________________________

Sex: male ☐ female ☐ trans ☐ other ☐ Phone Number: ______________________

Address: _____________________________________ Postal Code: ______________________________

Occupation:____

Attending Physician

Name: _______________________________ Phone No:________________________________

Lab Information

a) anti-HCV test: Reactive Yes ____ Date Collected: ______________________________________
b) Hepatitis C RNA testing has been ordered: Yes ____ No ____
If yes and result known, please attach lab result.

History of Hepatitis

Reasons for testing: ____

Symptomatic yes ☐ no ☐ Please specify:____

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Vaccination History

Vaccines received: Hepatitis A vaccine: yes ☐ no ☐ immune __ Hepatitis B vaccine: yes ☐ no ☐ immune __

Hepatitis A and B vaccine is available to Elgin County physicians and nurse practitioners free of charge for clients testing positive for Hepatitis C. Clients can also access these vaccines from the Sexual Health department at Elgin St. Thomas Public Health.

Risk History

Injection or **snort** drug use **within last year** yes ☐ no ☐ unknown ☐ When:_______________________
Past drug use: yes ☐ no ☐ unknown ☐ When:________________________
Received blood or blood product transfusion: yes ☐ no ☐ unknown ☐ When & Where:_________________
Occupational exposure: yes ☐ no ☐ unknown ☐ When:________________________
Organ transplantation: yes ☐ no ☐ unknown ☐ When:________________________
Known contact of Hep.C:
(household, sexual, drug use, etc.) yes ☐ no ☐ unknown ☐ When:________________________
Person with tattoos / body piercing: yes ☐ no ☐ unknown ☐ When:________________________
Born to and/or breast fed by infected mother: yes ☐ no ☐ unknown ☐ When:________________________
Other: yes ☐ no ☐ unknown ☐
Please specify: ____________________________________

Follow-up Information

Is the client aware he/she has Hepatitis C? yes ☐ no ☐
Has the client donated blood? yes ☐ no ☐ If yes, where and when:___________________
To protect the health of the public, we will contact Canadian Blood Services about the donation or receiving of blood.

Additional Comments: ____

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Name of Physician:_____________________ **Signature:**_____________________ **Date:**__________________

ATTENTION: , RN, BScN, Public Health Nurse **FAX (519) 631-1682**

EHU125B (Jan/16)