



Washoe County District Health Department
Hepatitis C Surveillance (HCS)

Please complete this form and fax it back to
 Communicable Disease Control Program Tel:
 775-328-2447 Fax: 775-328-3764

CASE REPORT

Record No.

A. PERSONAL AND REPORTING INFORMATION

Last First Middle Also Known As
 Address City State
 Zip code SSN Patient's phone Date of report from lab
 Physician Physician's medical group
 Physician's phone Reporting Lab
 Physician's fax LabCorp AML UniLab State Lab Blood Bank BioMat Others

B. DEMOGRAPHIC INFORMATION

Date of birth (mm/dd/yyyy) Gender Male Female Unknown
 Race/Ethnicity American Indian/Alaska Native, non-Hispanic Asian/Pacific Islander, non-Hispanic African American or Black, non-Hispanic
 White, non-Hispanic Hispanic (including all races w/Hispanic origin) Other races, non-Hispanic Unknown

C. REASON FOR TESTING (Check one box)

Symptoms of acute hepatitis Follow-up testing for previous marker of hepatitis Prenatal screening
 Screening of asymptomatic patient w/ risk factors Evaluation of elevated liver enzyme Other reasons
 Screening of asymptomatic patient w/o risk factors Blood / organ donor screening Unknown

D. CLINICAL DATA (Check the box that applies, Y=Yes N=No U=Unknown)

Cirrhosis Y N U Liver cancer Y N U Pregnancy Y N U

E. TEST RESULTS (Check the box that applies, P=Positive N=Negative B=Borderline U=Unknown)

	P	N	B	U		P	N	B	U	Genotype for HCV			
anti-HAV (total)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HAV (IgM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> 1	<input type="radio"/> 1a	<input type="radio"/> 1b	
HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc (total)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> 2	<input type="radio"/> 2a	<input type="radio"/> 2b	<input type="radio"/> 2c
anti-HBc (IgM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> 3	<input type="radio"/> 3a	<input type="radio"/> 3b	<input type="radio"/> 3e
anti-HCV (RIBA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HCV (EIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> other	<input type="radio"/> >=2 types	<input type="radio"/> Unknown	
					HCV RNA qualitative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

HCV RNA quantitative result ALT (SGPT) Date of ALT result

F. PAST HISTORY (Check all that apply. If no past history available, check the box "Unknown")

Alcohol abuse Blood transfusion/organ transplant prior to 1992 Receipt of clotting factor concentrates made prior to 1987
 Hemodialysis Injection Drug Use Multiple Sex Partners
 Contact to Hepatitis Employment involving contact with human blood Other risk factors Unknown

G. PRESENT HISTORY (Check the box that applies, Y=Yes N=No U=Unknown)

	Y	N	U		Y	N	U
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A vaccine received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B vaccine received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

H. DIAGNOSIS FOR HCV Acute hep C Chronic HCV infection Resolved HCV infection Date/Year of Diagnosis
ADDITIONAL DIAGNOSIS Acute hep A Acute hep B Chronic HBV infection