NJ DEPARTMENT OF HEALTH COMMUNICABLE DISEASE SERVICES

HEPATITIS C CASE INVESTIGATION FORM

CDRSS #:

PATIENT INFORMATION

Name *Last* *First* *Middle*

Address *Street*

Apt. *City* *County*

State *Zip*

Phone

Email

DOB / / **Age** Years

If child <36 months, is the mother HCV+?
☐ Yes ☐ No ☐ Unknown

Ethnicity
☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown

Race
☐ White ☐ Black ☐ Asian
☐ American Indian or Alaskan Native
☐ Native Hawaiian/Hawaiian / Pacific Islander
☐ Other/Unknown

Sex
☐ Male ☐ Female ☐ Other / Unknown

DIAGNOSIS

Has patient been diagnosed with hepatitis C at any time in the past? ☐ Yes ☐ No ☐ Unknown

*If "Yes" - **Dates of PREVIOUS diagnosis and illness onset:***

↳ *Diagnosis:* / / ↳ *Onset:* / /

If "No" – **Date of illness onset for NEW diagnosis:** / /

↳ **Patient informed of NEW diagnosis?** ☐ Yes ☐ No ☐ Unknown

↳ **Disease information provided?** ☐ Yes ☐ No ☐ Unknown

↳ **Did this include information about prevention and control?**
☐ Yes ☐ No ☐ Unknown ☐ N/A

CLINICAL SYMPTOMS

Did the patient have any symptoms?
☐ Yes ☐ No ☐ Unknown

If "Yes", provide onset date and symptoms that apply →

☐ Fever ☐ Malaise
☐ Anorexia ☐ Nausea
☐ Diarrhea ☐ Jaundice
☐ Abdominal Pain ☐ Other:

Date of earliest symptom onset: / /

LABORATORY INFORMATION

Reason for current hep C testing:
☐ Symptoms ☐ Routine testing ☐ Reported Risk Factors
☐ Prenatal Screening ☐ Other:

In the past 12 months, did patient have a negative Hep C test result?
☐ Yes ☐ No ☐ Unknown

Most recent lab tests: ☐ *No Tests Performed*

Test	Anti-HCV	HCV RNA PCR	HCV Genotype	ALT (SGPT)	AST (SGOT)	Bilirubin
Result						
Date	/ /	/ /	/ /		/ /	

RISK FACTORS

Patient ever have contact with person known to have hep C? *(indicate type of contact)*	☐ *Household Member (non-sexual)* ☐ *Sex Partner* ☐ Other:	☐ Yes	☐ No	☐ Unknown
Lifetime number of sexual partners? *(indicate number)*	*# Male* *# Female*			☐ Unknown
Patient ever incarcerated for more than 24 hours?	*Type of facility:*	☐ Yes	☐ No	☐ Unknown
Patient ever receive a blood transfusion?	☐ Yes (before 1992) ☐ Yes (after 1992)		☐ No	☐ Unknown
Patient ever accidentally punctured with a needle or other object soiled with blood?		☐ Yes	☐ No	☐ Unknown
Was patient ever treated for a sexually transmitted disease?		☐ Yes	☐ No	☐ Unknown
Patient ever had a tattoo?		☐ Yes	☐ No	☐ Unknown
Patient ever had a body piercing?		☐ Yes	☐ No	☐ Unknown
Patient ever exposed to someone else's blood? ***(medical, dental, public safety blood worker)***		☐ Yes	☐ No	☐ Unknown
Patient ever undergone hemodialysis?		☐ Yes	☐ No	☐ Unknown
Patient ever injected drugs not prescribed by a doctor?		☐ Yes	☐ No	☐ Unknown
Patient had dental work or oral surgery within the last 6 months?		☐ Yes	☐ No	☐ Unknown
Patient currently a resident of a long-term care facility?		☐ Yes	☐ No	☐ Unknown

General comments or other risk factors:

Is there anything in patient's history that warrants further public health investigation?
☐ Yes → Please explain:
☐ No ☐ Unknown

Please return the completed form to:

Local Health Department Name
Address, P.O. Box, City, State, Zip
Contact Name (First, Last)
Contact Title
Contact Email Address
Phone # | Fax #

Name of Clinical Contact: ***Email:*** ***Date Sent (to LHD):*** / /

CDS-17
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