Report of Hepatitis C - Please use this form for reporting LAB CONFIRMED Hepatitis C
Fax completed form to 905-940-4541 - Please forward lab and / or provide lab details

Health Care Provider Information:	**Name:** **Address:** **Phone:** **Fax:**	
Client Information:	**Legal Name:** **Preferred Name:** **Pronoun(s):** **Gender Identity:** **Address:**	**DOB:** **Sex (assigned at birth):** **Language:** **Phone:**

CONFIRMED HEPATITIS C ANTIBODY LAB REPORT DATE: _____

HEPATITIS C CLASSIFICATION

Are HCV RNA test results available or have been ordered?

☐ NO – please order ☐ YES - Date of RNA Test: _____

HCV RNA Result: ☐ Detected ☐ Not detected* ☐ Pending

** York Region Public Health will not follow cases with undetectable Hepatitis C RNA. Please provide health teaching on historical Hepatitis C exposure, risk of reinfection and discuss contact notification. On request, Public Health can assist with anonymous notification.*

Does the client have a previous negative anti-HCV or HCV RNA test from the past 24 months?

☐ NO/Unknown ☐ YES – Date of previous test: _____

Does the client have clinically compatible signs and symptoms? ☐ NO ☐ YES

Symptom(s): _____ Onset date: _____

Has client been tested for hepatitis A and B? ☐ YES ☐ NO (Testing advised)

Is client currently on OR have a history of hepatitis C treatment? ☐ NO ☐ YES – Year: _____

Is client being referred to a specialist? ☐ YES - Specialist: _____ Appt Date: _____

PRENATAL - Is this client pregnant? ☐ YES – EDD: _____

CONTACT NOTIFICATION (NEWLY ACQUIRED or RNA POSITIVE/UNKNOWN CASES ONLY)

Indicate who is responsible to complete:

☐ **Client** - Client has taken responsibility to inform contacts

☐ **Health Care Provider** - Health care provider will provide each contact with notification and testing

☐ **Public Health** - Client has requested anonymous notification of contact(s).
Contact Name/Phone: _____

☐ **Unable to Follow** - Client does not have sufficient information for contact(s)

☐ **Not discussed with client**

To order free hepatitis A and/or B vaccine for clients meeting eligibility criteria:

- For York Region Health Care Providers send completed High Risk vaccines order form via fax to (905) 830-0578,via email to vaccineinventory@york.ca or call 1-877- 464-9675 Ext. 74033.
- For Health Care Providers outside York Region, contact your local Health Unit.

HEPATITIS C HEALTH EDUCATION

☐ YES ☐ NO – Client is informed of their hepatitis C status and provided with health teaching.

York Region Public Health recommends health teaching include:

- Client has been notified of their hepatitis C result. For RNA positive/unknown clients, include strategies to decrease hepatitis C transmission including safer sex and new, sterile/single use needles and inhalation supplies. Harm reduction supplies for drug use are available at no cost – visit ohrdp.ca/find-supplies
- Client to notify contacts including those exposed to shared drug equipment, household, sexual and other contacts and advise they be assessed for hepatitis C.
- For any RNA positive clients, review benefits of linkage to hepatitis C medical care as >95% cases are curable with access to highly effective treatment
- Inform client not to donate blood, organs, tissue, semen or breast milk
- Free hepatitis A and B immunization available for this client at no cost through Public Health
- If applicable, advise client to refer to their professional college for further infection reporting and any practice recommendations/restrictions

Would you like Hepatitis C health information mailed to this client? ☐ YES

Reasons for Hepatitis C Testing

☐ Routine screening ☐ Contact Tracing ☐ Immigration ☐ Insurance ☐ Prenatal ☐ Other _____

Have other SBBI tests been done (indicate results)?

☐ Chlamydia ☐ Gonorrhea ☐ Hepatitis B ☐ HIV _____ ☐ Syphilis

ASSESSMENT OF RISK FACTORS

Medical Risk Factors	Behavioural Social Factors
☐ Client born to a case or carrier	☐ Travel/live in country where hepatitis C is endemic
☐ Born in an endemic country: _____	☐ Contact is hepatitis B positive
☐ Received Blood or blood products: When: _____ Where: _____	☐ Occupational Exposure: _____
☐ Dialysis Recipient: When: _____ Where: _____	☐ Acupuncture ☐ Electrolysis
☐ Invasive medical/surgical procedures: When: _____ Where: _____	☐ Tattoo ☐ Piercing
☐ Organ/Tissue transplant: When: _____ Where: _____	☐ Other Personal Service: _____
☐ Pregnant – EDD: _____	☐ Correctional Facility ☐ Homeless/Underhoused
☐ Partially/Incompletely immunized	☐ Inhalation Drug Use ☐ Injection Drug Use
☐ Unimmunized	☐ Intranasal Drug Use ☐ Shared Drug Equipment
☐ Positive HIV status	☐ Shared Personal items i.e. razors, toothbrushes
☐ On HIV Pre-Exposure Prophylaxis (PrEP)	☐ Fighting/Biting/Blood brother
☐ Repeat STI _____	☐ High Risk Sexual Activity ☐ Sex with same sex
☐ Other: _____	☐ Sex with opposite sex ☐ Sex with transgender
	☐ Sex with sex trade worker ☐ Sex trade worker
	☐ Other: _____

Comments: _____

HCP Name/Signature: _____ Date: _____

Submit Form ☐