VERMONT
DEPARTMENT OF HEALTH

Hepatitis C Report Form

Health Department Internal Use

Investigation started	____/____/___
Contact with patient	☐Yes ☐No
Date of contact	____/____/___
Case status updated	____/____/___
Notification sent	____/____/___

Patient:

Patient Name:_____

DOB:_____/_____/_____ Sex: ☐Male ☐Female

Home Phone:_____

Address:_____

REQUIRED: Town:_____ County: _____

Race: (circle all that apply):

☐White ☐African American ☐Native American ☐Hawaiian/Pacific Islander ☐Asian ☐Other_____

Ethnicity: ☐Hispanic ☐Non-Hispanic

Provider:

Ordering Provider:_____ Phone:_____

Provider Practice:_____

Specimen collected____/____/____ Lab Report Date____/____/____ Reported to VDH:____/____/____

REQUIRED: Hepatitis C Tests:	Positive	Negative	Unknown	Date
1. Antibody Test (anti-HCV by EIA)	☐	☐	☐	____/____/___
2. Supplemental anti-HCV assay (eg RIBA)	☐	☐	☐	____/____/___
3. HCV RNA (eg PCR)	☐	☐	☐	____/____/___
4. HCV Antigen Test *(development and approval pending)*	☐	☐	☐	____/____/___
5. HCV Genotype Testing Type_____	☐	☐	☐	____/____/___
6. Previous negative HCV antibody test within 12 mos.	☐Yes	☐No	☐Unknown	____/____/___

7. Liver Enzyme levels: ALT/SPGT: _____ AST/GOT:_____

HCV Classification (refer to numbered Hepatitis C Tests listed above and clinical criteria* below)

☐**Acute HCV, Confirmed:** Meets clinical criteria* and has Positive 3 or 4 **or** positive tests 1,2,3,or 4 and 'yes' to 6

☐**Acute HCV, Probable:** Meets clinical criteria*, positive tests 1 or 2, and 'no' to 6

☐**Chronic HCV, Confirmed:** Does not meet clinical criteria*, has positive 3 or 4, and 'no' to 6

☐**Chronic HCV, Probable:** Does not meet clinical criteria*, has positive 1 or 2, and 'no' to 6

***Clinical Criteria** (must meet a. and either b. or c. criteria)

a.) An illness with discrete onset of any sign or symptom consistent with acute viral hepatitis: ☐Yes ☐No - If 'yes' please check: ☐Fever, ☐Headache, ☐Malaise, ☐Anorexia, ☐Nausea, ☐ Vomiting, ☐Diarrhea, ☐Abdominal pain, ☐Other_____

AND

b.) Jaundice: ☐Yes ☐No - If 'yes', date of onset ____/____/____

OR

c.) A peak elevated serum ALT level >200 IU/L during the period of acute illness: ☐Yes ☐No

Other Hepatitis Tests:	Positive	Negative	Unknown	Date
IgM antibody to hepatitis A	☐	☐	☐	____/____/___
Hepatitis B surface antigen (HbsAg)	☐	☐	☐	____/____/___
Total antibody to hepatitis B core antigen (anti-HBc)	☐	☐	☐	____/____/___

Other:_____

To return this form: SECURE FAX: 802-951-4061
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Questions: Roy Belcher, 802 951 4065

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