

Ohio Department of Health Hepatitis C Case Collection Form

Patient Demographics

Date Completed: / /

Last name		First name		Middle name (or initial and/or suffix)	
Alternate name (i.e. alias, married/maiden)		Address (number and street)		County	
City		State	Zip code	Phone ()	
Address type <input type="checkbox"/> Residential <input type="checkbox"/> Correctional facility <input type="checkbox"/> Institutional <input type="checkbox"/> Foster home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary <input type="checkbox"/> Unknown					
Birthdate (month/day/year) / /	Age	Sex at birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant at diagnosis of HCV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	Delivery date / /	
Race (check all that apply) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____			Ethnicity (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Place of birth <input type="checkbox"/> USA <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Current gender identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Declined to answer <input type="checkbox"/> Not asked <input type="checkbox"/> Unspecified <input type="checkbox"/> Other (specify): _____					

Facility Information

Diagnosing provider		Diagnosing facility name	
Facility address		Phone ()	Facility type <input type="checkbox"/> Hospital <input type="checkbox"/> Private physician's office <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Other (specify): _____

Clinical Information

Reason for testing <input type="checkbox"/> Post-vaccine serology <input type="checkbox"/> Prenatal screening <input type="checkbox"/> Year of birth (1945-1965) <input type="checkbox"/> Unknown <input type="checkbox"/> Blood/organ donor screening <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Screening of symptomatic patient <input type="checkbox"/> Screening of asymptomatic patient with NO risk factors <input type="checkbox"/> Screening of asymptomatic patient with reported risk factors		Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, complete the following: Treatment start date: / / Treatment end date: / / <input type="checkbox"/> Currently in treatment
Symptoms of acute hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, symptom onset date: / /		
Was the patient jaundiced? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, jaundice diagnosis date: / /		
Was the patient aware they had viral hepatitis prior to lab testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Does the patient have a provider of care for hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Does the patient have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, diabetes diagnosis date: / /		

Laboratory Information

Hepatitis C		Previous HCV? <input type="checkbox"/> Yes <input type="checkbox"/> No	ODRS number: _____
Test 1: <input type="checkbox"/> Anti-HCV <input type="checkbox"/> HCV RNA <input type="checkbox"/> HCV genotype <input type="checkbox"/> ALT		Date collected: / /	
Result 1: <input type="checkbox"/> Positive/reactive <input type="checkbox"/> Negative/non-reactive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Numeric value: _____		Result date: / /	
Test 2: <input type="checkbox"/> Anti-HCV <input type="checkbox"/> HCV RNA <input type="checkbox"/> HCV genotype <input type="checkbox"/> ALT		Date collected: / /	
Result 2: <input type="checkbox"/> Positive/reactive <input type="checkbox"/> Negative/non-reactive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Numeric value: _____		Result date: / /	
Test 3: <input type="checkbox"/> Anti-HCV <input type="checkbox"/> HCV RNA <input type="checkbox"/> HCV genotype <input type="checkbox"/> ALT		Date collected: / /	
Result 3: <input type="checkbox"/> Positive/reactive <input type="checkbox"/> Negative/non-reactive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Numeric value: _____		Result date: / /	
In the 12 months prior to the first positive test result, did the patient have a documented NEGATIVE HCV test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, complete the following: Test type: <input type="checkbox"/> Anti-HCV Date: / / <input type="checkbox"/> HCV RNA Date: / / <input type="checkbox"/> HCV genotype Date: / /			
Hepatitis B		Previous HBV? <input type="checkbox"/> Yes <input type="checkbox"/> No	ODRS number: _____
Was the patient tested for Hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Hepatitis B status? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Resolved <input type="checkbox"/> Unknown	
HIV		Previous HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No	ODRS number: _____
Was the patient tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		HIV status? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	

Epidemiology Information and Risk Factors

Contact risk factors

Has the patient had contact with a person with hepatitis infection (confirmed or probable, acute or chronic)? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, what type of contact: <input type="checkbox"/> Sexual <input type="checkbox"/> Household (non-sexual) <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
Has the patient had an accidental stick or puncture with a needle or other object contaminated with blood? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the patient had other exposure to someone else's blood? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, specify exposure: _____
Has the patient been incarcerated for longer than 24 hours? <input type="checkbox"/> Yes, for a period of LESS than 6 months <input type="checkbox"/> Yes, for a period GREATER than 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, year of most recent incarceration: _____ Length of most recent incarceration (in months): _____ If YES, what was the type of facility? <input type="checkbox"/> Jail (city or county) <input type="checkbox"/> Prison (state or federal) <input type="checkbox"/> Juvenile
WITHIN the 12 months before HCV diagnosis, did the patient receive a tattoo? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, where was the tattooing performed? <input type="checkbox"/> Commercial shop <input type="checkbox"/> Correctional facility <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
WITHIN the 12 months before HCV diagnosis, did the patient have any part of their body pierced (other than ear)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, where was the piercing performed? <input type="checkbox"/> Commercial shop <input type="checkbox"/> Correctional facility <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____

Sexual risk factors

Has the patient been treated for a sexually-transmitted disease (STD)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, year of most recent treatment: _____
How many sexual partners has the patient had (approximate lifetime number of partners)? _____
WITHIN the 12 months before HCV diagnosis (ask both of the following questions regardless of the patient's gender): How many FEMALE sex partners did the patient have? _____ How many MALE sex partners did the patient have? _____

Drug-related risk factors

Has the patient used street drugs but did not inject? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, specify drug(s): _____
Has the patient injected drugs NOT prescribed by a doctor, even if only once or a few times? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, specify drug(s): _____ If YES, when did the patient LAST inject drugs? <input type="checkbox"/> < 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> 6+ years ago If YES, when did the patient FIRST inject drugs? <input type="checkbox"/> < 6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> 6+ years ago

Healthcare-related risk factors

Has the patient undergone hemodialysis? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the patient had any IV infusions and/or injections in the outpatient setting? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the patient received blood or blood products (transfusion)? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, was the transfusion received prior to 1992? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did the patient receive an organ transplant prior to 1992? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did the patient receive clotting factor concentrate produced prior to 1987? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
WITHIN the 12 months prior to HCV diagnosis, did the patient have dental work (other than routine cleaning) or oral surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
WITHIN the 12 months prior to HCV diagnosis, did the patient have surgery (other than oral)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the patient been a resident of a long-term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Occupational risk factors

Was the patient employed in a medical or dental field involving direct contact with human blood? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, frequency of direct blood contact in medical field: <input type="checkbox"/> Frequently or several times weekly <input type="checkbox"/> Infrequently <input type="checkbox"/> Unknown
Was the patient employed as a public safety worker (fire fighter, law enforcement, or correctional officer) having direct contact with human blood? <input type="checkbox"/> Yes, LESS than 12 months before HCV diagnosis <input type="checkbox"/> Yes, GREATER than 12 months before HCV diagnosis <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, frequency of direct blood contact as a public safety worker: <input type="checkbox"/> Frequently or several times weekly <input type="checkbox"/> Infrequently <input type="checkbox"/> Unknown

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