

Hepatitis C Initial Presentation

Presentation Date: ___/___/___ Site: _____ Clinician: _____

*PLEASE NOTE that case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in this clinical setting. **Always use Patient ID# when presenting a patient in clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws.***

Screening Encounter Date: ___/___/___ (required)

General Information/Demographics

Patient ECHO ID:		Age:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Ethnicity – Hispanic or Latino:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Race:	<input type="checkbox"/> American Indian, Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black, African American <input type="checkbox"/> Native Hawaiian, Pacific Islander <input type="checkbox"/> White		
Insurance:	<input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid, MCO: _____ <input type="checkbox"/> Commercial Health Insurance: _____ <input type="checkbox"/> Other: _____		

Suspected Route of HCV Transmission (Check all that apply)

Suspected Route of Transmission	Yes	Description
Current or former injection drug user (even once)	<input type="checkbox"/>	If yes, Injection Drug Use in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Recipient of clotting factor concentrates made before 1987	<input type="checkbox"/>	
Blood transfusion or solid organ transplant before July 1992	<input type="checkbox"/>	
Needlestick injury in healthcare setting	<input type="checkbox"/>	
Birth to an HCV-infected mother	<input type="checkbox"/>	
Sex with an HCV infected person	<input type="checkbox"/>	
Sharing contaminated personal items, such as razors or tooth brushes with an HCV infected person	<input type="checkbox"/>	
Non-professional tattoo	<input type="checkbox"/>	
Unknown	<input type="checkbox"/>	

Medical Diagnoses (Check all that apply)

Liver Related History (select all that apply)	Yes	Description/Comments
HCV	<input type="checkbox"/>	Year of diagnosis: _____
Cirrhosis	<input type="checkbox"/>	Any evidence of decompensation? <input type="checkbox"/> Ascites <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Variceal bleed
Previous HCV Treatment	<input type="checkbox"/>	Year: _____ Drug Regimen: _____ Duration of treatment in weeks: _____
Liver Biopsy	<input type="checkbox"/>	Year: _____ Results: _____
Hepatocellular Carcinoma	<input type="checkbox"/>	Year of diagnosis: _____

Medical Diagnoses (select all that apply)	Yes	Description/Comments
Asthma	<input type="checkbox"/>	
Auto Immune Disease	<input type="checkbox"/>	Type of disease: _____
Brain Injury	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	Year: _____ Type of Cancer: _____
Chronic Pain	<input type="checkbox"/>	
COPD	<input type="checkbox"/>	
Coronary Artery Disease	<input type="checkbox"/>	
Cryoglobulinemia	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>	
Hepatitis B, chronic	<input type="checkbox"/>	
HIV	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	
Peripheral Neuropathy	<input type="checkbox"/>	
Renal Insufficiency	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	
Solid Organ Transplant	<input type="checkbox"/>	Year of transplant: _____ Organ transplanted: _____

Hepatitis Vaccinations and Labs

Vaccination/Labs	Description/Comments
Is patient immune to hepatitis A?	REMINDER: Patients with hepatitis C need to be vaccinated for both hepatitis A and B.
Hepatitis B surface antigen (HBsAg)	
Hepatitis B surface antibody (anti-HBs)	
Hepatitis B core antibody (anti-HBc)	

Psychiatric Diagnosis

Psychiatric Diagnosis	Yes	Description
Depression	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	If yes, is patient on medication for anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mania/Hypomania	<input type="checkbox"/>	If yes, is patient on medication for Mania/Hypomania? <input type="checkbox"/> Yes <input type="checkbox"/> No

Survey Scores

PHQ-9 Score:		Date of survey: ___/___/_____
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Substance Use History

Substance Use History	Yes	No	Description/Comments
Does patient currently drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If no, has the patient ever had a drinking problem? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last drink: ___/___/_____
Does patient currently use drugs other than alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check all that apply: <input type="checkbox"/> Opiates <input type="checkbox"/> Stimulants (cocaine, amphetamine, etc.) <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Marijuana
Does patient smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	

Current Medications: (Please include dosage)

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Body Mass Index

Height:		<input type="checkbox"/> Centimeters	<input type="checkbox"/> Inches
Weight:		<input type="checkbox"/> Kilograms	<input type="checkbox"/> Pounds
BMI:			

Laboratory

Basic Laboratories			
Date of Lab Draw:		___/___/___	
WBC		INR	
ANC		Albumin	
HGB		ALT	
HCT		AST	
Platelets		Alk Phos	
Creatinine		T. Bili	
Glucose		Direct Bili	
Prottime		Total Prot	

Other Essential Results	Date	Result
Fe	___/___/___	
TIBC	___/___/___	
Ferritin	___/___/___	
Vitamin D 25-OH	___/___/___	
AFP	___/___/___	
HIV Ab	___/___/___	
HCV Genotype	___/___/___	
HCV Viral Load	___/___/___	
Other:	___/___/___	

APRI =	
FIB-4 =	
MELD =	
Child-Pugh=	

For Clinical Calculators (APRI, FIB-4, MELD, etc.), visit:

hepatitisc.uw.edu/page/clinical-calculators/meld