New Jersey Department of Health and Senior Services

HEPATITIS C REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race

☐ White ☐ American Indian ☐ Unknown/Other
☐ Black ☐ Asian

Ethnicity

☐ Hispanic ☐ Unknown
☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Probable ☐ Confirmed

Is patient symptomatic? ☐ Yes ☐ No

Laboratory Data (attach copy of results)

Screening Test: Enzyme Immunoassay (EIA)*** or Enzyme Linked Immunosorbent Assay (ELISA) Positive Date: _____ ☐ Signal to cutoff result positive

Liver Function Tests:

ALT (SGPT): Date: _____ ☐ Not Done

AST (SGOT): Date: _____ ☐ Not Done

Bilirubin: Date: _____ ☐ Not Done

Confirmatory Tests:

RIBA (Recombinant Immunoblot Assay) Date: _____ ☐ Positive ☐ Negative ☐ Not Done

HCV RNA (RT-PCR) Qualitative Date: _____ ☐ Positive ☐ Negative ☐ Not Done

HCV RNA (RT-PCR) Quantitative (viral load) Date: _____ ☐ Positive ☐ Negative ☐ Not Done

HbsAg: ☐ Positive ☐ Negative ☐ Not Done

IgM anti-HAV: ☐ Positive ☐ Negative ☐ Not Done

****If HCV EIA has signal to cutoff result positive ratio (S/Co) equal to or greater than 3.8, the test is considered confirmatory.*

Liver Biopsy (please attach report): Date: _____ ☐ Not Done

Is patient being treated for Hepatitis C, or has patient been treated in the past? ☐ Yes ☐ No

Risk Factors:

The following questions are provided as a guide for the investigation of lifetime risk factors for HCV infection. Routine collection of this information is not required. However, collection of risk factor information may provide useful information for the development and evaluation of programs to identify and counsel HCV-infected persons.

Did the patient receive a blood transfusion prior to 1992? ☐ Yes ☐ No ☐ Unknown

Has the patient ever injected drugs not prescribed by a doctor, even if only once? ☐ Yes ☐ No ☐ Unknown

Has the patient had multiple sexual partners? ☐ Yes ☐ No ☐ Unknown

Has the patient had a tattoo or body piercing? ☐ Yes ☐ No ☐ Unknown

Was the patient ever incarcerated? ☐ Yes ☐ No ☐ Unknown

Other, specify: _____

Name of Person Submitting Report	Title	Telephone Number
Name of Reporting Health Office/Representative	**Name of Health Department**	**Date**