PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Viral Hepatitis C (HCV) Investigation Questionnaire for Healthcare Providers

Demographic Information

Client name (last, first):	**DOB *(yyyy/mm/dd)*:**
Home phone:	**Cell phone:**

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other, please specify:

Primary HCP:	**Primary HCP phone:**

Current address:

Address type:

If other address type, please specify:

Healthcare facility or other congregate setting contact person and phone number (*if applicable*):

Permanent address:

Address type:

If other address type, please specify:

Healthcare facility or other congregate setting contact person and phone number *(if applicable)*:

Country of birth:	**Country of last residence:**	**Arrival date in Canada:**

Primary language:	**Interpreter required:**

Client has proxy:	**Proxy name, relationship, and contact information (*if applicable*):**

Diagnostic Information

Most recent specimen result:

HCV RNA

HCV RNA viral load: **Genotype:**

Client aware of most recent result:	**Previous test date(s) and locations (*if applicable*):**

Reason for testing:

- ☐ Symptoms (see below)
- ☐ Blood donation notification
- ☐ Contact tracing/post exposure
- ☐ Elevated LFTs
- ☐ Client request
- ☐ Screening based on risk
- ☐ Immigration screening
- ☐ Routine screening
- ☐ Prenatal screening
- ☐ Maternal exposure
- ☐ Insurance medical screening
- ☐ Other (please specify):

Symptom onset date (if applicable)

Symptoms:

- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Dark urine
- ☐ Other:
- ☐ Jaundice
- ☐ Pale stool
- ☐ Malaise/fatigue
- ☐ Loss of appetite/weight
- ☐ Arthralgia/joint pain
- ☐ Fever

Hospitalized:	**Location and date of admission (*if applicable*):**
Date of death (*if applicable*):	**Cause of death (*if applicable*):**

Ongoing Care

HCV RNA viral load ordered:	**If yes, collection date:**
If no HCV RNA viral load ordered, please indicate reason:	
Referral to specialist:	**Treating provider/specialist name or centre:**
Treating provider/specialist phone:	**Appointment date:**
If no referral made, please indicate reason:	

Hepatitis A vaccination:	**Hepatitis B vaccination:**	**Immunity to Hepatitis A and Hepatitis B**
Date(s) of immunization or immunity testing (*if applicable*):		
Other vaccinations:		

Risk Factor Information

Medical risk factors:

- ☐ Born in an endemic country (location):
- ☐ Born to an HCV case
- ☐ Organ/tissue transplant (date and location):
- ☐ Dialysis recipient (location):
- ☐ Invasive medical/surgical procedure (date and location)
- ☐ Pregnant (EDD):
- ☐ Received blood/blood products (date and location):
- ☐ HIV co-infected
- ☐ Invasive dental procedures (date and location):
- ☐ Unknown
- ☐ Other (please specify):

Behavioural/social risk factors:

- ☐ High risk sexual activity
- ☐ Contact is HCV positive
- ☐ Contact is HIV positive
- ☐ Injection Drug use
- ☐ Inhalation drug use
- ☐ Intranasal drug use
- ☐ Shared drug equipment
- ☐ Shared personal items (e.g., toothbrush, razor)
- ☐ Sex worker
- ☐ Acupuncture
- ☐ Electrolysis
- ☐ Homeless/underhoused
- ☐ Correctional facility
- ☐ Tattoo
- ☐ Piercing
- ☐ Other personal services
- ☐ Fighting, biting, blood brother
- ☐ Healthcare worker
- ☐ Occupational exposure to potentially HCV contaminated body fluids
- ☐ Unknown
- ☐ Other (please specify):

Additional risk factor details provided by the client:

Health Teaching

Health teaching provided:	**If no, please indicate reason:**

- ☐ Healthy lifestyle and healthy living with HCV
- ☐ Importance of regular HCV monitoring *
- ☐ Treatment available
- ☐ Vaccinations
- ☐ If pregnant, HCV testing for infant after birth
- ☐ Harm reduction
- ☐ Co-infection/re-infection is possible
- ☐ Access/barriers to follow-up care
- ☐ Transmission prevention (see below)
- ☐ Other (please specify):

DO cover open wounds, clean up blood with freshly prepared bleach solution (1 part bleach: 9 parts water), and dispose of blood contaminated items (e.g., feminine hygiene products, bandages, cloths) in a plastic bag; safely dispose of sharps; disclose HCV status to HCPs (and current/future sexual partners); and practice safer sex (e.g.., condoms, dental dams etc.).

DO NOT donate blood, tissue, semen, or human milk; share drug paraphernalia; or share personal hygiene items (e.g., nail clippers/scissors/files, dental floss, toothbrush, razors, and glucometers).

*As per the Provincial Infectious Diseases Advisory Committee on Communicable Diseases (2014), it is reasonable to encourage annual testing for individuals with ongoing risk exposures.

Contact Investigation

Contacts discussed with client: **Client agrees that they will notify contacts:**	**If client does not agree to notify contacts, contact notification to occur by:** If WDGPH to complete contact notification, provide the following information regarding contact(s).

Contact name:	**DOB (*yyyy/mm/dd*):**	**Phone and address:**	**Contact type:**
			☐ Household ☐ Sexual ☐ Shared drug equipment ☐ Blood exposure ☐ Other
			☐ Household ☐ Sexual ☐ Shared drug equipment ☐ Blood exposure ☐ Other
			☐ Household ☐ Sexual ☐ Shared drug equipment ☐ Blood exposure ☐ Other
			☐ Household ☐ Sexual ☐ Shared drug equipment ☐ Blood exposure ☐ Other

Additional Comments

Signature of provider completing questionnaire:	**Date:**
Client aware WDGPH may follow up:	**Please fax completed questionnaire to 1-855-934-5463.**

The information on this form is collected under the authority of the Health Protection and Promotion Act in accordance with the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. This information will be used for the delivery of public health programs and services; the administration of the agency; and the maintenance of healthcare databases, registries and related research, in compliance with legal and regulatory requirements. Any questions about the collection of this information should be addressed to the Chief Privacy Officer at 1-800-265-7293 ext. 4339.