Reset Form

RAPID HCV ANTIBODY AND HCV RNA POC TEST REPORTING

State Form 57736 (R / 9-25)
INDIANA DEPARTMENT OF HEALTH

INSTRUCTIONS: 1. COPY AND FAX COMPLETED FORMS TO THE IDOH VIRAL HEPATITIS SURVEILLANCE TEAM AT 317-233-7663

PATIENT INFORMATION			
First Name	Last Name		Middle Name
Street Address			
City	County	State	ZIP-code
Home Telephone Number	Other Telephone Number		Email
Sex: ☐ Male ☐ Female ☐ Unknown ☐ Choose not to answer			Date of Birth (mm/dd/yyyy):
Sexual Orientation: ☐ Bisexual ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Other: _____			
Race (Check all that apply): ☐ Caucasian ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Unknown ☐ Other(specify): _____			
Hispanic Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown			
How did you learn about this hepatitis C testing opportunity? ☐ Radio ☐ Newspaper ☐ Text message ☐ Flyer ☐ Website ☐ Social media (Facebook, X/Twitter, Instagram) ☐ Other (put in comments)			
Has the patient been previously diagnosed with hepatitis C? ☐ Yes ☐ No ☐ Unknown Date _____			
If yes, has the patient been previously treated for hepatitis C? ☐ Yes ☐ No ☐ Unknown Date _____			
If yes, has the patient previously cleared the virus? ☐ Yes ☐ No ☐ Unknown Date of last known negative HCV RNA: _____			

CLINICAL INFORMATION	
Testing Date (mm/dd/yyyy):	Is the patient jaundiced? ☐ Yes ☐ No
Is the patient experiencing symptoms of acute hepatitis (including: fever, headache, malaise, anorexia, nausea, vomiting, diarrhea or abdominal pain)? ☐ Yes ☐ No	
Rapid HCV Antibody Test Result: ☐ Reactive ☐ Non-Reactive ☐ Invalid	
HCV RNA Point of Care (POC) Test Result: ☐ Detected ☐ Not-Detected ☐ Invalid Specimen ID: _____	

TESTING AGENCY
Name of Tester
Name of Testing Agency
Agency County
Agency Phone Number

RISK FACTOR QUESTIONS		
	Ever	**In last 6 months**
1. Used a needle to inject drugs?	☐ Yes ☐ No	☐ Yes ☐ No
1a. **If yes**, shared other equipment?	☐ Yes ☐ No	☐ Yes ☐ No
2. Snorted or smoked drugs?	☐ Yes ☐ No	☐ Yes ☐ No
2a. **If yes**, shared drug use equipment?	☐ Yes ☐ No	☐ Yes ☐ No
3. Experienced incarceration for longer than 24 hours?	☐ Yes ☐ No	☐ Yes ☐ No
3a. **If yes**, Prison?	☐ Yes ☐ No	☐ Yes ☐ No
3b. **If yes**, Jail?	☐ Yes ☐ No	☐ Yes ☐ No
3c. **If yes**, Juvenile Facility?	☐ Yes ☐ No	☐ Yes ☐ No
4. Contact with someone living with hepatitis C?	☐ Yes ☐ No	☐ Yes ☐ No
4a. **If yes**, sexual contact?	☐ Yes ☐ No	☐ Yes ☐ No
4b. **If yes**, household contact?	☐ Yes ☐ No	☐ Yes ☐ No
4c. **If yes**, other contact (specify) :_____	☐ Yes ☐ No	☐ Yes ☐ No
5. Received non-commercial tattoo(s) or piercing(s)?	☐ Yes ☐ No	☐ Yes ☐ No
6. Experienced homelessness or unstable housing?	☐ Yes ☐ No	☐ Yes ☐ No
7. Worked in medical or dental field involving direct contact with human blood?	☐ Yes ☐ No	☐ Yes ☐ No
8. Had multiple sex partners?	☐ Yes ☐ No	☐ Yes ☐ No

COMMENTS OR ADDITIONAL INFORMATION