Reset Form

RAPID HCV TEST REPORTING

State Form 57736 (3-25)
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)			

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	
Test Result: ☐ Reactive ☐ Non-reactive ☐ Invalid	

RISK FACTOR QUESTIONS	Ever	In last 6 months
1. Previously diagnosed with Hep C?	☐ Yes ☐ No	☐ Yes ☐ No
2. Used a needle to inject drugs?	☐ Yes ☐ No	☐ Yes ☐ No
2a. **If yes**, shared needles, syringes, or other equipment?	☐ Yes ☐ No	☐ Yes ☐ No
3. Snorted or smoked drugs?	☐ Yes ☐ No	☐ Yes ☐ No
3a. **If yes**, shared drug use equipment?	☐ Yes ☐ No	☐ Yes ☐ No
4. Experienced incarceration for longer than 24 hours?	☐ Yes ☐ No	☐ Yes ☐ No
4a. **If yes**, Prison?	☐ Yes ☐ No	☐ Yes ☐ No
4b. **If yes**, Jail?	☐ Yes ☐ No	☐ Yes ☐ No
4c. **If yes**, Juvenile Facility?	☐ Yes ☐ No	☐ Yes ☐ No
5. Contact with someone living with Hep C?	☐ Yes ☐ No	☐ Yes ☐ No
5a. **If yes**, sexual contact?	☐ Yes ☐ No	☐ Yes ☐ No
5b. **If yes**, household contact?	☐ Yes ☐ No	☐ Yes ☐ No
5c. **If yes**, other contact (specify) :_____	☐ Yes ☐ No	☐ Yes ☐ No

	Ever	In last 6 months
6. Received non-commercial tattoo(s) or piercing(s)?	☐ Yes ☐ No	☐ Yes ☐ No
7. Experienced homelessness or unstable housing?	☐ Yes ☐ No	☐ Yes ☐ No
8. Worked in medical or dental field involving direct contact with human blood?	☐ Yes ☐ No	☐ Yes ☐ No
9. Had multiple sex partners?	☐ Yes ☐ No	☐ Yes ☐ No

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

COMMENTS OR ADDITIONAL INFORMATION