

# HEPATITIS C

## HEALTHCARE PROVIDER INVESTIGATION & REPORTING FORM

The Health Protection and Promotion Act 1990 (HPPA), R.S.O., 1990, and Ontario Reg. 135/18, outlines the requirements for physicians, practitioners, and institutions to report **any suspect or confirmed disease of public health significance** to the Medical Officer of Health.

This form is required to be completed and faxed within one working day of the initial patient assessment to the Windsor-Essex County Health Unit (WECHU) – Infectious Disease Prevention Department (fax: 226-783-2132).

<b>DATE REPORTED (YYYY/MM/DD)</b>		<b>REPORTING PROVIDER NAME</b>		<b>PHONE NUMBER</b> (      )      ext.	
<b>SECTION A: PATIENT INFORMATION</b>					
<b>PATIENT NAME</b> (FIRST)      (MIDDLE)      (LAST)			<b>SEX</b>	<b>DATE OF BIRTH (YYYY/MM/DD)</b>	
<b>ADDRESS</b> (STREET)      (CITY)      (POSTAL CODE)					
<b>HOME PHONE:</b> (      )			<b>ALTERNATE PHONE:</b> (      )		

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client been notified of the laboratory result, indicating infection?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you believe this is a newly acquired infection (<24 months)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the client pregnant?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client received or been offered Hep C RNA testing to determine whether they have active infection or have cleared the virus (spontaneously or through treatment)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client been referred to a specialist or a Hepatitis C program?

<b>SECTION B: PRESENTING SYMPTOMS</b>			
<input checked="" type="checkbox"/> SIGNS & SYMPTOMS	Onset Date (YY/MM/DD)	<input checked="" type="checkbox"/> SIGNS & SYMPTOMS	Onset Date (YY/MM/DD)
<input type="checkbox"/> Asymptomatic (most common)		<input type="checkbox"/> Elevated liver enzymes	
<input type="checkbox"/> Right-sided abdominal discomfort		<input type="checkbox"/> Malaise	
<input type="checkbox"/> Anorexia		<input type="checkbox"/> Nausea	
<input type="checkbox"/> Easily bruised or bleeding		<input type="checkbox"/> Rash	
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Dark urine	
<input type="checkbox"/> Fever		<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Jaundice		<input type="checkbox"/> Other, specify:	

<b>SECTION C: RISK FACTORS</b>	
<input type="checkbox"/> Birth in an endemic region	<input type="checkbox"/> Unprotected sex, multiple sexual partners
<input type="checkbox"/> Travel to/residence in endemic region	<input type="checkbox"/> Those with street involvement/homeless.
<input type="checkbox"/> IV drug use	<input type="checkbox"/> Inhalation/intranasal drug use
<input type="checkbox"/> Had a needlestick injury	<input type="checkbox"/> Tattoos/piercings
<input type="checkbox"/> Receiving hemodialysis	<input type="checkbox"/> Shared sharp instruments or personal hygiene materials with someone who is HCV positive
<input type="checkbox"/> Received blood transfusions, blood products or organ transplants in Canada before 1992	<input type="checkbox"/> Received health care where there is a lack of routine precautions
<input type="checkbox"/> Has been incarcerated	<input type="checkbox"/> Other, specify:

SECTION C: PATIENT EDUCATION	
<input type="checkbox"/>	Counsel client regarding how hepatitis C is transmitted and prevention methods.
<input type="checkbox"/>	Encourage client to receive both hepatitis A and B vaccines. Hepatitis A and B vaccines are <b>free</b> when health care providers order through the Health Unit. The vaccine order form can be found on the Health Unit website: <a href="#">High Risk Hepatitis Vaccine Order Form</a>
<input type="checkbox"/>	Advise client to inform their contacts who may have had blood-to-blood exposure (including their sexual partner(s)) to follow up with a health care provider and get tested.
<input type="checkbox"/>	Inform client that a nurse from the Health Unit will be contacting them. They may also call the Health Unit directly at 519-258-2146 ext. 1420.

REPORTING HEALTHCARE PROVIDER'S SIGNATURE: \_\_\_\_\_

The most current form is available on our website:

<https://www.wechu.org/forms/>

For more information: 519-258-2146 ext. 1420

Infectious Disease Prevention

www.wechu.org

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