DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

Hepatitis C Case Report

Patient Name: Last: _____ First: _____ Middle: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone #:

DEMOGRAPHIC INFORMATION

RACE: (Check all that applies):

American Indian: ☐ Alaska Native: ☐ Black or African American: ☐ White: ☐

Asian: ☐ Native Hawaiian or Pacific Islander: ☐ Other Race, specify: _____

ETHNICITY: Hispanic: ☐ Non-Hispanic ☐ Unknown: ☐

DATE OF BIRTH: _____ **PLACE OF BIRTH:** USA ☐ Other: _____

SEX: Male ☐ Female ☐ Transgender: ☐ **PREGNANT DURING INFECTION?** Yes ☐ No ☐

CLINICAL & DIAGNOSTIC TESTS

TESTING DETAILS:

Test/Screening Date: ___/___/___ Reason for test/screening: _____

CLINICAL:

	YES	NO	ONSET DATE
Patient symptomatic?	☐	☐	___/___/___
Jaundice	☐	☐	___/___/___
Abdominal Pain	☐	☐	___/___/___
Fever	☐	☐	___/___/___
Headache	☐	☐	___/___/___
Anorexia	☐	☐	___/___/___
Malaise	☐	☐	___/___/___
Nausea	☐	☐	___/___/___
Vomiting	☐	☐	___/___/___
Diarrhea	☐	☐	___/___/___

LAB RESULT:

	RESULT	TEST DATE
LIVER ENZYME:		
ALT	_____	___/___/___
AST	_____	___/___/___
Bilirubin	_____	___/___/___
ANTI – HCV POSITIVE with the signal cut off ratio > 3.8	_____	___/___/___
NAT HCV RNA	_____	___/___/___
HCV GENOTYPE	_____	___/___/___

Physician Name:_____ **Date:**_____

Address: Street:_____ **Phone#:**_____ **FAX#**_____

City:_____ **State:**_____ **Zip Code:**_____

***Please Fax Completed Form to (302) 739-2549**

Revised Jan 2016