



Doctor Name _____

Hospital/Practice _____

Address _____

Postcode _____

Office Use Only	
DoH ID:	_____
Date Sent:	___ / ___ / ___
Date Received:	___ / ___ / ___
Data Updated by CDCB:	<input type="checkbox"/>

Dear Doctor,

ENHANCED HEPATITIS C SURVEILLANCE

I understand that you recently diagnosed a **hepatitis C virus (HCV) infection** in the patient indicated below. We are requesting further information about this case in order to enhance surveillance of HCV in Western Australia. The additional information will enable better definition of risk factors, detection of changes in transmission patterns and distinction between newly acquired and chronic infections.

Your assistance in completing as much of the questionnaire as possible is greatly appreciated. If you think it appropriate that we contact the patient to seek the information required, please complete the patient contact details below. **Your patient will not be contacted without your explicit request.**

If this case has not yet been notified to the Department of Health, completion of the questionnaire will also satisfy your legal requirement to do so. A self-addressed pre-paid envelope is enclosed for your convenience.

Thank you for your assistance.

Dr Gary Dowse
MEDICAL EPIDEMIOLOGIST
COMMUNICABLE DISEASE CONTROL DIRECTORATE

Patient Details		<i>(strictly confidential)</i>	
Name or Name Code* :	_____	_____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
<small>*First 2 letters of:</small>	Family Name	Given Name	
Date of Birth:	___ / ___ / ___	Country of Birth:	<input type="checkbox"/> Australia <input type="checkbox"/> Other Specify: _____
	dd mm yyyy		
Post Code of Residence:	____	Ethnicity :	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Non-Aboriginal <input type="checkbox"/> Unknown
Patient Contact Details - please complete if you prefer the Department of Health to contact the patient directly for information			
Address: _____			
Phone No.: _____			
Has the patient been advised that the Department of Health may contact him/her? <input type="checkbox"/> Yes <input type="checkbox"/> No			

* Please ring (08) 9388 4852 if you would like to clarify the identification of this patient

HCV Diagnosis

a) Date of test for this notification: __ / __ / __ → Test Results: ▶ HCV-Ab ▶ HCV-rna

Pos	Neg	Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

dd mm yyyy

b) Has this patient had a previous **negative** test? Yes No Unk → If yes, Date: __ / __ / __
(Most recent negative test)

c) Has this patient had a previous **positive** test? Yes No Unk → If yes, Date: __ / __ / __
(First known positive test)

d) Is this a **recently acquired** HCV infection? (within past 2 years)

Yes Patient has been a documented **seroconversion** within the past 2 years
and/or (ie. Patient had a negative HCV-antibody test within past 2 years but is now positive)

Yes Patient is HCV-antibody positive and has had a clinical illness consistent with **acute hepatitis** (where other causes of hepatitis have been excluded) within past 2 years Date of onset of hepatitis: __ / __ / __

No No documented seroconversion or acute hepatitis within past 2 years
This case will therefore be classified as a **non-specified / chronic** HCV infection

Reasons for Testing

(Please tick one or more)

- History of risk factors (eg. injecting drug use, tattoos, body piercing, needle-stick injury, HCV contact)
- Signs/symptoms of hepatitis (includes elevated LFTs)
- Routine screen (specify) Prison
- Antenatal
- Sexual health
- Defence force
- Blood donor
- Drug /alcohol program
- Peri-operative
- Occupational exposure - exposed
- Occupational exposure - source
- Patient request specify _____
- Other reason specify _____

Risk Factors

Please indicate if your patient has **ever** had any of the following risk factors and if any have occurred within the **2 years (<2yrs) prior to diagnosis**.

Yes < 2 yrs	Yes Ever	No	Don't know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Injecting drug use
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Transfusion / transplant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Blood products/tissues in Australia Date: __ / __ / __
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Blood products/tissues overseas Date: __ / __ / __
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Dialysis dd mm yyyy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Skin penetration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Needlestick/biohazardous injury in a healthcare setting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Needlestick/biohazardous injury to a person in a community setting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Surgical procedure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Major dental surgery
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Tattoos
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Acupuncture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Ear piercing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Body piercing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Perinatal exposure (born to HCV+ mother)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Sexual partner with HCV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Imprisonment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Health care worker with no documented exposure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Household contact with HCV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	▶ Other risk factor specify _____

▶ **No risk factors identified**

▶ **No information available**

Thank you for completing this questionnaire.