



Hepatitis C

Charlie Crist
Governor

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Hepatitis C Report Form

Please complete this form and fax back to (305) 470-5533 along with the results of the patient's hepatitis panel, including Liver Enzyme Levels and confirmatory tests.

Part I: Demographics

Date: _____

Patient name:

(Last) (First) (M.I.)

Birthdate: _____

Occupation: _____

Address: _____
(Street / Apt. #)

Phone: _____
(home)

(City) (State) (Zip Code)

(work)

Sex: ___ Male
 ___ Female

Race: ___ American Indian/Alaskan Native
 ___ Asian or Pacific Islander
 ___ Black
 ___ White

Ethnicity: ___ Hispanic
 ___ Non-Hispanic

Clinical Information

Was patient hospitalized for hepatitis? [Yes] [No] [Unk]

If yes, name of hospital: _____ Date of Admission: _____ Discharge: _____

Was this patient diagnosed clinically with acute or chronic hepatitis C? ___ Acute ___ Chronic

Date of diagnosis: ___/___/___ Symptoms? [Yes] [No] [Unk] If yes, date of onset: ___/___/___

Has the patient had hepatitis B? [Yes] [No] [Unk]

If no, has the patient received the hepatitis B vaccine? [Yes] [No] [Unk]

Dates? _____ All three doses? [Yes] [No] [Unk]

Has the patient had hepatitis A? [Yes] [No] [Unk]

Has the patient received the hepatitis A vaccine? [Yes] [No] [Unk]

Dates? _____ Both doses? [Yes] [No] [Unk]

Please Mark Symptoms:

Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk
Jaundice				Dark Urine				Abd. pain			
Nausea				Light stools				Fatigue			
Vomiting				Fever				Other			

Hospital _____ ☎: _____ 📠: _____

Name of person completing form: _____ ☎: _____

Comments: _____



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