Hepatitis C Notification Form

Panorama QA complete: ☐ **Yes** ☐ **No**
Initials:

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address: Phone number:	***FOR PUBLIC HEALTH OFFICE USE ONLY:*** **Service Area:** **Date Received:** **Panorama Client ID:** **Panorama Investigation ID:**

B) CLIENT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____ Health Card Province: _____ Health Card Number (PHN):	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other Gender Identity: ☐ Transgender Male-to-female ☐ Transgender Female-to-male ☐ Undifferentiated ☐ Other (specify)	Phone : ☐ Primary Home: ☐ Mobile contact: ☐ Workplace: ☐ Alt Contact: Name: _____ Relationship: _____
Place of Employment/School:	Email Address:	Preferred Communication Method: ☐ Home ☐ Work ☐ E-mail ☐ Text

Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description

Mailing (Postal address):

Street Address or FN Community (Primary Home):

C) IMMIGRATION INFORMATION

Country Born In: _____

Country Emigrated from: _____ Arrival Date: YYYY / MM / DD OR Arrival Year YYYY

D) DISEASE EVENT HISTORY

Staging: ☐ Acute (19 months of age and older) ☐ Chronic (19 months of age and older) ☐ Unstaged (less than 19 months of age)
☐ Resolved (19 months of age and older) ☐ Unstaged (19 months of age and older)

E) SIGNS & SYMPTOMS (NOTE: For Public Health - Do not select "ONSET" symptom)

Description	No	**Yes** **Date of onset**	**Add'l Info**
Asymptomatic			
Jaundice			
Lab – aminotransferase levels - elevated			
Lethargy (fatigue, drowsiness, weakness, etc.)			
Loss of appetite (anorexia)			
Nausea			
Pain - Abdominal			
Urine – dark			
Vomiting			
Weight loss			
Other – specify			

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Initials:

F) RISK FACTORS Please complete *all* Risk Factors from LAST KNOWN NEGATIVE result –specify dates as needed) **N—No, NA–Not asked, U–Unknown**

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Contact – Hepatitis C	YYYY / MM/DD		
Exposure – Invasive body art (e.g. tattoo, body piercing, scarification)	YYYY / MM/DD		
Exposure – Blood and body fluids (not otherwise listed) (Add'l Info)	YYYY / MM/DD		
Occupation – Health Care Worker – IOM Risk Factor			
Risk Behavior – Sharing injection drug equipment	TE		
Risk Behavior – Sharing non-injection drug equipment	TE		
Sexual Behaviour – More than 2 sexual partners in past 3 months	TE		
Sexual Behaviour – MSM	TE		
Sexual Behaviour – Sex with a known case (Add'l Info)	YYYY / MM/DD		
Sexual Behavior – Sex with person from endemic country (Add'l Info)	YYYY / MM/DD		
Sexual Behavior – Sex with person who injects drugs	TE		
Special Populations – Correctional Facility resident			
Special Population – From or residence in an endemic country			
Special Population – Infant born to infected mom	TE		
Special Population – Pregnancy			
Special Population – Self-reported indigenous			
Substance Use – Alcohol			
Substance Use – Injection Drug Use (including Steroids)			
Substance Use – Illicit non-injection drug use	AE		
Travel – Outside of Canada (Add'l Info)	YYYY / MM/DD		
Other risk factor (Add'l Info)	TE		
Medical Treatment – Blood, blood product or tissue recipient (Add'l Info)	YYYY / MM/DD INTERVENTION		
Medical Treatment – Other (transplant, surgery, dental, oscopy, artificial insemination etc.) (Add'l Info)	YYYY / MM/DD INTERVENTION		
Blood, blood product, tissue or transplant ***donor***	*Document referral in Interventions and complete Appendix K – Referral to CBS, and upload into Document Management*		

G) UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts:_____ (number of contacts that the individual cannot name)

Include known contacts on the following pages

Hepatitis C - Contacts

Case Name:

Page _____ of _____

Please complete **all** sections.

Please include information on additional contacts on a separate sheet

A) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ alternate phone: Relationship:	**e-mail Address:**	
Online Names: Site/Service: User Name:		
Place of Employment/School:	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is contact HIV positive** ☐ Yes ☐ No ☐ Unknown **Is this contact Hep C positive?** ☐ Yes ☐ No ☐ Unknown	
Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description **Mailing** (Postal address): **Street Address** or **FN Community** (Primary Home):		
Exposure Dates: 1st YYYY / MMM / DD to YYYY / MMM / DD **Exposure Type**: ☐ Sexual ☐ Sharing Injection/Non-injection Drug Equipment ☐ Household		
Comments:	**INTERVENTION** **Testing** ☐ Advised ☐ Received ☐ **Referral** (Specify)	

B) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ alternate phone: Relationship:	**e-mail Address:**	
Online Names: Site/Service: User Name:		
Place of Employment/School:	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is contact HIV positive** ☐ Yes ☐ No ☐ Unknown **Is this contact Hep C positive?** ☐ Yes ☐ No ☐ Unknown	
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Comments:	**INTERVENTION** **Testing** ☐ Advised ☐ Received ☐ **Referral** (Specify)	