1. **Purpose:**
	1. To support appropriate and consistent public health management of hepatitis C investigations within in the WRHA.
2. **Scope and Goal:**
	1. Public Health Nurses (PHNs) working within the WRHA will follow-up hepatitis C infections as per [Manitoba Health Communicable Disease Control Protocol](https://www.gov.mb.ca/health/publichealth/cdc/protocol/hepc.pdf).
3. **Background:**
	1. Hepatitis C infection is reportable under the Reporting of Communicable Diseases Regulation of the *Public Health Act*, schedule B, for which partner notification is not a requirement. However, if a person who carries hepatitis C wishes for public health to notify individuals who may have been exposed to them in a manner that potentiates transmission, the PHN may do so according to the procedure in this guideline.
	2. The testing practitioner is primarily responsible for notifying, counseling, and treating/referring patients with hepatitis C infections (i.e. cases) for appropriate care.
	3. PHNs will make reasonable efforts to ensure that cases have been notified of results, provided with basic information regarding hepatitis C infection and care (including relevant immunizations), appropriately referred for care, and interviewed for transmission risks with a focus on public health and preventing onward transmission.
	4. Cases identified as high-probability for poor outcomes and/or onward transmission will be prioritized (e.g. people actively involved in injection drug use and equipment sharing, people who experience barriers to accessing health services). As contemporary treatments are highly effective, additional support to link the individual with hepatitis C services can have positive impact on the individual and the larger community
	5. The number of contact attempts and risk criteria detailed in this clinical practice guideline do not necessarily represent best practice, but are based on prioritization of workload related to current overall STBBI volume in the WHR.
4. **Procedure:**
	1. Healthy Sexuality and Harm Reduction (HSHR) administrative staff will identify positive hepatitis C lab results (via the lab workload report)/ PHIMS investigations and assign the corresponding investigations in PHIMS to the appropriate PHN as follows.
		1. Investigations where a HSHR PHN is the tester, the testing site is Winnipeg Remand Centre or Manitoba Youth Centre, if there is a co-infection with another STBBI (open investigation), or there is a history of a previous HIV diagnosis will be assigned to a HSHR PHN for follow up.
		2. For all other hep C investigations, HSHR admin will assign to the centralized PH admin team, who will circulate to the appropriate CA team for review and follow up.
	2. **Previous Infections:** Electronic lab reports will indicate “This patient previously tested positive for Hepatitis C virus” within the result details description. Staff can also note that a result is associated with a previous infection on the lab workload report if the “entered date” is more than a few days after the “report date” or on the investigation search report if the “reported date” is more than 2 weeks in the past.
		1. The previous paper chart is not pulled by admin or routinely reviewed by a PHN. It is important to note that for many clients who were diagnosed prior to regional use of PHIMS, incomplete documentation in PHIMS does not necessarily reflect that an investigation did not take place. The PHN may decide in certain circumstances (such as a request from a HCP) to pursue the client if it is noted that the client’s initial investigation is not complete.
		2. If no follow up is indicated, the PHN will make a note in the PHIMS investigation indicating that the client has previous history of HCV, no public health follow-up indicated at this time.
		3. If there is an indication that the client is pregnant (e.g. lab slip indicates prenatal testing, or testing practitioner is a midwife or ObGyn) but no additional Hepatitis C follow up is indicated, a letter will be sent to testing practitioner recommending infant screening 12-18 months after birth (see Appendix A). If client serology history suggests viral clearance (two negative HCV-RNA results drawn at least 3 months apart), a letter will be sent to testing practitioner recommending repeat PCR testing if there is suspicion of reinfection (see Appendix B).
		4. Occasionally there may be an outstanding open hepatitis C investigation in PHIMS. If the outstanding investigation is open to the Winnipeg STBBI workgroup, and has been open more than 6 months, the investigation may be closed and the disposition can be changed accordingly (e.g. risk assessment indicates no need for follow up, follow up complete). Historic records should be indicated in PHIMS by entering the first positive date in the classification (Disease Summary screen), if the original diagnosis took place in Manitoba prior to the use of PHIMS (Sept 1/ 2018). The classification and staging should always reflect the original diagnosis, thus the staging should not be updated to “old case- previously diagnosed in MB” when subsequent results are received.
		5. When repeat serology is received and PHN notes that client was not previously notified- send a letter (Appendix E) to the care provider advising them client was not previously notified of their infection and that a referral to Hepatology is outstanding. If client was tested through ER/Urgent care, check to see if there is new contact information for the client. If new demographic information available, the PHN can attempt contact.
		6. When reviewing serological history on eChart, if there is a history of a resolved infection (2 negative HCV-RNA tests, drawn at least 3 months apart) and the new result indicates either core antigen or RNA positive, this should be pursued as a re-infection. In this scenario, a new investigation should be created in PHIMS.
	3. **New Infections:** On receipt of what appears to be a new hepatitis C infection, the PHN will:
		1. **Open PHIMS investigation**:
			* Update disposition to “follow up in progress”
			* Update the classification to “lab confirmed”
			* Check eChart for most recent locating/demographic information and update in PHIMS
			* Check eChart lab history to see when client was last tested for hepatitis C; including HCV PCR– to inform staging (see case definition and staging 4.11).
			* Check eChart lab history for immunity to HBV and HAV
			* Check eChart/ PHIMS for immunization history for HBV, HAV
			* Summarize above in an introductory note with investigation in context.
			* If managed by HSHR PHN:

The PHN will utilize the CLN (see Operational Guideline: Clinic Liaison Nurse Process) to contact testing practitioner for baseline information and care plan when necessary.

* + - * If managed by CA PHN:

PHN will connect with testing practitioner directly for baseline information and care plan within 24 hours.

* + 1. **Diarize file:** Using office specific processes (i.e. for HSHR, create entry on shadow log).
	1. **Clinic Contact:** For new hepatitis C cases managed by the CA, the PHN will contact the testing practitioner directly to discuss test results and determine if client notified of results, determine testing practitioner’s plan, reason for testing and whether client was symptomatic or asymptomatic. See Appendix F- Hepatitis B & C Health Care Provider Worksheet to help guide communication with care provider. The primary care testing practitioner will be advised of:
		1. Recommendation for HAV/HBV vaccine as required (Manitoba Health provides vaccine free of charge to HCV positive clients)
		2. Availability of specialists for consultation once initial work-up is done (it is role of testing practitioner and not PHN to refer client for hepatitis C care, however the PHN may refer a client directly to the Mount Carmel Community Hep C clinic if the testing provider is unable (e.g. people tested through emergency departments). HIV and hepatitis C co-infected individuals are managed by the HIV program.
		3. Clients require public health follow up regardless of hepatitis C RNA-PCR results. A positive RNA-PCR, or positive core antigen result confirms an active hepatitis C infection, and referral to a hepatitis C specialist is recommended. A client with hepatitis C antibodies and a negative HCV-PCR can be referred to Mount Carmel Hepatitis C Clinic, or seen by the primary care provider for follow up HCV-PCR testing. Referrals should be made by the testing practitioner if sending the client to the viral hepatology unit. One repeat negative HCV-RNA result, drawn at least 3 months apart (for a total of 2 negative tests) indicates viral clearance if the client has not been re-exposed during this period.
		4. The PHN will attempt to contact the client to complete outstanding aspects of investigation. In most instances, a phone call will be attempted. If the PHN is unable to contact the case, a letter will be sent in a plain envelope (see Hepatitis C Case Follow-Up Algorithm; see Important Health Matter letter template on WRHA letterhead) when followed by HSHR. If followed by a CA PHN, a doorstop visit may be more appropriate. Cases with a greater likelihood of poor outcomes or of transmitting infection are prioritized for Public Health follow up.

If the testing site is a hospital and information regarding stay/ locating information is not available on eChart (i.e. situation where individual is tested without identifiers, “unknown male”), the CA PHN can consider checking with the HSHR CLN who has access to EDIS and may be able to gather additional details to guide follow up.

* 1. **PHN Interview and Education** should be person-centred, focused on building trust, and grounded in harm reduction. The following components are generally included:
		1. Introduction
* Privacy ensured and case identity confirmed
* Confidentiality assured
* Introduction of self & PHN role
	+ 1. Clinical history, Counseling/Education
* Symptoms and onset
* Discuss other testing
* Assess and supplement person’s knowledge of hepatitis C (transmission, chronic infection, treatment)
* Discuss hepatitis C transmission and prevention
* Potential consequences of hepatitis C (chronic liver disease)
* Harm reduction information and resources as indicated (including how to prevent further harm to the liver)
* Reinforce importance of medical evaluation for chronic liver disease. For prenatal clients, medical evaluation is also important although hepatitis C treatment is not recommended during pregnancy and breastfeeding.
* Hepatitis A and hepatitis B vaccination is recommended, if client is susceptible and are available free of charge.
* Referral to appropriate resources and plan for follow up care (vaccination, follow up HCV RNA PCR testing, referral for hepatitis C provider).
	+ 1. Risk assessment
* Discussing transmission and exposure risk for hepatitis C is for the benefit of the client’s understanding of hepatitis C, to inform of possible public health risk (e.g. potentially infectious blood bank product), and to gather population surveillance information to understand infection dynamics. Rapport and trust with clients is priority in these conversations, and the client should be informed they can decline answering questions related to their own risk. The focus of risk assessment should be on blood borne infection transmission risks and relevant social context (see Appendix C for further detail). Risk factors that are relevant to HCV include:
	+ Recipient of blood/blood products (see Section 4.8 Blood Services)
	+ Donor of blood/blood products (see Section 4.8 Blood Services)
	+ Other potential blood exposure: Intravenous drug use (IVDU), non-professional tattoo, piercing, fights, sex that may involve blood, endemic considerations, historic medical procedures.
	1. **Contacts/Partner notification:**
		1. Under the Public Health Act, universal contact interview and notification by the PHN is not required for hepatitis C, and contacts related to injection drug use equipment sharing are not likely to be disclosed without trust and rapport with the provider. Hepatitis C cases should be encouraged to discuss with their long-term sexual contacts, but the PHN does not need to generate a contact investigation for that person. In the case of IVDU contacts, efforts can be made to gather details to facilitate contact follow up. If the PHN does gather contact details for the purpose of pursing contact notification, this information should be recorded in PHIMS.
		2. If the STBBI contact form is received from the testing practitioner or from out of region, the information should be recorded in PHIMS via a transmission event/ contact investigation. Contacts will be assessed by the PHN to determine follow up. PHN will assess follow-up of contacts based on the significance of exposure, feasibility of notification, and the prioritization of partners at risk. Sexual contacts to hepatitis C will not be routinely contacted. Priority contacts include:
	+ known regular/repeat injection drug (equipment) sharing partners, with
	+ no prior testing or history of negative hepatitis C antibody results and
	+ firm locating information provided

Based on these criteria if the PHN decides to pursue the contact, at least 3 contact attempts should be made.

* + 1. If the PHN determines contact follow up will not occur, the disposition of “risk assessment indicates no need for follow up” should be used and the contact investigation should be closed.
		2. The PHN should also address any concerns and questions which household members and long term sexual partners may have.
		3. For prenatal clients and infants born to hepatitis C positive mothers, The PHN will send a copy of the ‘hepatitis C prenatal letter’ (see Appendix A) to the testing practitioner, advising them of recommended testing for infants. In the circumstance that testing occurs at the time of the delivery (ie. client does not have prenatal care); rather that advising the maternal testing practitioner it would be reasonable to notify the guardian and/or the infant care provider directly. Infant testing for hepatitis C (HCV antibody testing is preferred over HCV PCR) is recommended at 12 to 18 months of age. An investigation will not be generated for the infant unless reactive serology results are received. Follow up is complete once testing practitioner has been notified of infant testing recommendations, the investigation does not need to be held open for results.
			- Prenatal and postpartum clients can be advised of the small chance of vertical transmission and that breastfeeding is not contraindicated (Manitoba Health, 2014). However, if the client is breastfeeding and the nipples and/or surrounding areola become cracked and bleeding, they should temporarily stop breastfeeding until their breasts are healed. Once their breasts are no longer cracked or bleeding, breastfeeding can be resumed (Perinatal Services BC, 2015).
	1. **Blood Services:**
		1. Risk associated with blood donation/ transfusion should be assessed for all cases by the practitioner, or by the PHN in the PHIMS risk assessment section.
		2. If there is reasonable possibility that the source of infection in a client testing positive for hepatitis C is the receipt of blood or blood products or there is a history of blood donation, the PHN will inform Canadian Blood Services. The PHN must proceed as follows:
* Inform the case that there is a reporting requirement to notify Canadian Blood Services of this information
* Complete the TDN (Transmissible Disease Notification) requirement [form](file:///%5C%5CAd.wrha.mb.ca%5Cwrha%5CCOMMUNITY%5CCentralized%5CSHARED%5CPUBLIC_HEALTH%5CHEALTHY_SEXUALITY_%26_HARM_REDUCTION%5CProcedures%20Manual%20HSHR%20team%5CSTBBI%20Guidelines%5CTDN%20reporting%20form%20Jan%202019.pdf).
* Fax completed form to Canadian Blood Services (fax number 1-844-836-6843) and they will proceed with their investigation process
* TDN Specialist of Canadian Blood Services’ contact number is 1-506-648-5076
	1. **Documentation:**
		1. The primary documentation source of hepatitis C cases is PHIMS. Any faxed documentation received from health care providers should be uploaded into PHIMS using “context documents”. All relevant information from such communications should be entered into PHIMS by the WRHA PHN. All permanent documentation should occur within PHIMS.
	2. **Connecting client with hepatitis C care:**
		1. For individuals co-infected with HIV and hepatitis C, hepatitis C care is generally provided by the Manitoba HIV program provider. Support should be provided to ensure the individual connects with the HIV Program, and that the person’s providers are aware of the hepatitis C infection.
		2. For individuals who are not co-infected with HIV, hepatitis C care options are the Mount Carmel Clinic hepatitis C program, or the Viral hepatitis Investigative Unit at HSC. The testing practitioner should refer to either program, but on occasion the PHN may be the referring practitioner. Support for connecting the client with hepatitis C care should be informed by principles of health equity.
	3. **Staging:**
		1. PHNs do not generally receive enough information in the course of case management to determine acute staging. The following information summarizes staging options.
			+ A portion of confirmed cases will have anti-hepatitis C Virus (HCV) antibodies in blood (anti-HCV Ab), as well as:
				- HCV Core antigen test, or a qualitative nucleic acid amplification test (NAAT) for hepatitis C virus RNA (HCV RNA).
				- OR detection of HCV RNA in blood

These meet the criteria for chronic staging UNLESS there is a record of negative anti-HCV Ab testing in the previous 12 months. In this case, the investigation can be staged as acute.

* + - * For other cases the PHN will only receive HCV antibody results. Positive antibodies can indicate an acute, chronic, or resolved infection. Current recommendation from Manitoba Health is to stage investigations with only a positive antibody result as chronic.
	1. **Closure:** The investigation is complete when the PHN is reasonably assured that the case has been adequately counseled, interviewed, and connected with care if prioritized. For non-prioritized clients, the PHN is not required to confirm referral prior to file closure. The case will also be closed if all available means of contacting the case and/or contacts have failed (see Hepatitis C Case Follow-Up Algorithm).
		1. Prior to closure, the PHN will ensure all critical fields highlighted in the closure checklist (see Appendix C) are completed in PHIMS.
		2. A closure note should be made in PHIMS with the investigation in context. The Case disposition should be updated accordingly, and the Disease Staging Summary updated to reflect the appropriate staging.
	2. **Repeat serology post closure:** When repeat serology is received and PHN notes that client was not previously notified- send a letter (Appendix E) to the care provider advising them client was not previously notified of their infection and that a referral to Hepatology is outstanding. If client was testing through ER/Urgent care check to see if there is new contact information for the client. If new demographic information available, make 1 contact attempt then return to close.
1. **Validation**

Manitoba Health Communicable Disease Control Branch (2014). Hepatitis C. <http://www.gov.mb.ca/health/publichealth/cdc/protocol/>.

Perinatal Services BC (2015). Newborn Nursing Care Pathway. http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Newborn/NewbornNursingCarePathway.pdf

1. **Recommended Reading**

Pinette GD, Cox JJ, Heathcote J, Moore L, Adamowski K, Riehl G. (2009) Primary Care Management of Chronic Hepatitis C: Professional Desk Reference. Public Health Agency of Canada & College of Family Physicians of Canada.

Sherman, M., Sharran, S., Burak, K., Doucette, K., Wong, W., Girhah, N., Yoshida, E., Renner, E., Wong, P., & Deschene, M., (2007). Management of chronic hepatitis C: Canadian Consensus Guidelines. Canadian Journal of Gastroenterology, 21(Supp C) 25C-34C. [www.hepatology.ca/cm/FileLib/hepC.pdf](http://www.hepatology.ca/cm/FileLib/hepC.pdf)

APPENDIX A

Hepatitis C Prenatal Letter- Template

<Dr’s name>

<Clinic name>

<Address>

Winnipeg, Manitoba <Postal Code>

**RE:** **[client name]**

**DOB:**

**PHIN:**

<Date>

Dear [Dr.’s name],

I am writing this letter with regards to [client’s name]’s recent hepatitis C serology results and to advise regarding the Public Health recommendations for infant screening. As per our records, [Client’s name] tested positive for hepatitis C on [date of testing].

The rate of vertical transmission (mother to baby) of hepatitis C is between 1-5%, thus screening of the infant is indicated. **Based on provincial and national guidelines, please relay to the infant’s care provider that testing for hepatitis C is recommended at 12 to 18 months of age.**

Additionally, to assist with both client and infant follow up in the future, we do encourage HCV PCR testing to rule out active infection in the client. If you have any questions, please feel free to contact me at [PHNs phone number].

Sincerely,

**[PHN name]**

Public Health Nurse

Health Sexuality and Harm Reduction

496 Hargrave Street, Winnipeg, MB

APPENDIX B

Hepatitis C Prenatal Letter Viral Clearance- Template

<Dr’s name>

<Clinic name>

<Address>

Winnipeg, Manitoba <Postal Code>

**RE:** **[client name]**

**DOB:**

**PHIN:**

<Date>

Dear [Dr.’s name],

I am writing this letter with regards to [Client’s name] recent hepatitis C serology results and to advise regarding the Public Health recommendations for infant screening. As per our records, [Client’s name] tested positive for hepatitis C on [date of initial contact]. Her serology indicated clearance of the virus on [date] and [date].

At this time infant screening is not indicated. However, if reinfection is suspected please repeat Hep C PCR to rule out active infection. If you have any questions, please feel free to contact me at [PHNs phone number].

Sincerely,

**[PHN name]**

Public Health Nurse

Health Sexuality and Harm Reduction

496 Hargrave Street, Winnipeg, MB

# Appendix C-

# PHIMS Closure Checklist for Hepatitis C Case Investigations

# **Demographics:** Confirm validated address and phone number have been entered into client demographics

# **Case classification/ staging:** Label as “lab confirmed”, staging will vary, “chronic” as default if both antibody and RNA/ core antigen positive. If only antibody testing completed, stage as unknown. See page 6 [**https://www.gov.mb.ca/health/publichealth/surveillance/docs/mhsu\_6780\_ug.pdf**](https://www.gov.mb.ca/health/publichealth/surveillance/docs/mhsu_6780_ug.pdf) for guidance regarding “previous diagnosis” staging. Ensure staging is added by 4 weeks.

# **Case disposition:** Specific disposition will depend on the specific clinical scenario, however appropriate dispositions at time of closure may include:

# Declined follow up

# Follow up complete

# Unable to complete/ locate

# **Address at time of initial investigation:** Verify appropriate address selected from drop down. **.** If in the last 12 months the client has been unsheltered, emergency sheltered, or provisionally sheltered as defined by[**https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition-1pager.pdf**](https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Furldefense.com%2Fv3%2F__https%3A%2F%2Fwww.homelesshub.ca%2Fsites%2Fdefault%2Ffiles%2FCOHhomelessdefinition-1pager.pdf__%3B!!IqQd2s6KUyvHwNLtrw!qvZb8XfU_HsxkgYPjpHrJcmNZJdPx3bbeqFrfQFyfHJMXfUsE6ict44XSfqDNXkonRTROsUsrTvjd6dlKeucx5Nr7ciucQ%24&data=05%7C01%7CDebbie.Nowicki%40gov.mb.ca%7C61f6aa88f2524771c89208daff0d4eb9%7Cabf64de92a5c4d77baa2a76265367d3a%7C0%7C0%7C638102730139447483%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=k%2BCoS7nv7W1umPiuZ%2FtCmrcm6SWxyK6XCTaUgpn6%2BEk%3D&reserved=0) **- add risk factor Housing Unstable**

# **Exposure summary:** If IVDU contacts were generated, ensure that contacts have been entered correctly and that follow up is either complete or that there is a clear plan for ongoing follow up. All contacts should be reflected in exposure summary, even if it is as an anonymous contact.

# **Signs and Symptoms:** Record both yes and no for all discussed with client/ HCP

# **Risk factors: social and exposure-related risk factors are defined on MHSU Surveillance form. For required risk factors, investigator must document a response: *yes, no, unknown, declined to respond, not asked.* Ensure inclusion of relevant risk factors associated with potential blood exposure. If client has a previous history of Hep C diagnosed out of Manitoba, detail should be recorded in the appropriate risk factor. Non-required risk factors may be explored if client does not identify any other likely acquisition risk, or other relevant issues that arise during the investigation.**

# **Closure Note:** Documentation should occur throughout investigation in the note section in accordance with regional documentation policies. Prior to closure, include a note summarizing completion of follow up/ what remains outstanding (if unable to locate client).

### Appendix D: Hepatitis C Case Algorithm

 (June 2023)

New Hepatitis C Case received by WRHA

PHN to review, assess context surrounding testing episode, connect with HCP to gather relevant detail as appropriate

Testing practitioner provides some detail but some outstanding parts of investigation remain

Testing practitioner will not provide follow-up (e.g. ER physicians)

Leave up to 2 phone messages for client. Hold 3 days for call back from message.

In addition to PHN interview and education, PHN to facilitate access to Mount Carmel Clinic Community Hep C program

If unable to reach case, send up to 2 PHN letters (esp. if different addresses. Hold 2 weeks for call back. (\*CA PHN can consider DSV in lieu of mailed letter)

If able to locate case, proceed with PHN interview and education

Close Case Investigation

If unable to reach and case is prioritized (e.g. not informed of test results, person injects drugs or is HIV positive), PHN may close case investigation or choose to discuss with CD coordinator at case review.

If client refuses contact, close case investigation.

HSHR PHN is assigned if: testing site is WRC/ MYC, HSHR is the tester, if there is a co-infection with another STBBI OR history of HIV infection

CA PHN assigned to all remaining investigations

Testing practitioner provide all detail needed to complete investigation

Appendix E

HCP Letter for Previous Diagnosis



1 – 496 Hargrave Street 1 – 496, rue Hargrave

Winnipeg, Manitoba Winnipeg, Manitoba

R3A 0X7 CANADA R3A 0X7 CANADA

Tel: 204-940-2210 Tél: 204-940-2210
Fax: 204-940-2007 Téléc: 204-940-2007
[www.wrha.mb.ca](http://www.wrha.mb.ca) www.wrha.mb.ca

Re:

PHIN

DOB

Date:

Dear Dr.,

I was the public health nurse assigned to \_\_\_\_\_\_\_\_ Hepatitis C case, initially diagnosed on \_\_\_\_\_. Public health had been unsuccessful in reaching this client to notify them of their results at time of diagnosis and the case is now been closed to Public Health per regional guidelines. As the testing provider, please notify the client of their diagnosis and refer them to HSC Viral Hepatology Unit for follow up.

Manitoba’s Hepatitis C Management Protocol can be found here for further management of this infection ,including publicly funded vaccine recommendations:

<https://www.gov.mb.ca/health/publichealth/cdc/protocol/hepc.pdf>

I will leave this in your capable hands. Please call me at \_\_\_\_\_\_ should you have any further questions.

Sincerely,

**RNBN**

Public Health Nurse

Appendix F

**Hepatitis B &/or C Health Care Provider Worksheet**

**Preamble**: To assist the PHN in obtaining relevant information, this worksheet can be used when engaging the physician/primary care provider in a telephone conversation.

Name:

DOB:

PHIN:

***Client Demographics***

Address:

Phone/email:

Need for an interpreter: □ Yes □ No If yes, specify language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Reason for test:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Client aware of results:*** □ Yes □ No If no, plan to notify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Symptoms check all that apply:***

□ Abdominal Pain □ Anorexia □ Dark Urine □ Fatigue

□ Fever □ Ocular Involvement □ Rash □ Fever

□ Jaundice □ Nausea □ Pale Stool □ Vomiting

Other (specify):

***Staging:***

□ Acute □ Chronic □ Unknown □ Previous Diagnosis □ Previous Diagnosis-New to MB

If previous hx, prompt for detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Pregnancy:***

□ Yes □ no EDD: YYYY-MM-DD Obstetrical care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Referred to Hepatology:*** □ Viral Hepatology Investigative Unit (HSC) □ Mount Carmel Clinic (hep c only)

***Risk Factors:***

□ History of incarceration □ Male who has sex with Men □ No identifiable risk factors

□ Injection drug use □ Shared Needles/ drug equipment □ residence in an endemic country

□ other blood exposures (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:

***Vaccinations initiated if susceptible (\*check immunization history prior to call):*** □HAV □HBV □Twinrix

***Contacts:*** (\*HAV is not publicly funded for contacts- unless they meet the MB Health eligibility criteria)

* Hep B- Identify potential household/ sexual exposures – i.e. Does the client have a partner, children
* Hep C – focus only on IVDU exposures x 1 year

\*\*Advise physician that PHN will be contacting the client to provide education and discuss contact follow-up.\*\*