

For reporting of Viral Hepatitis Cases among New York State Department of Corrections Inmates ONLY.  
Do not use for County Jail Inmates. Please complete and fax or mail to the appropriate Local Health Department.  
Questions? Call: New York State Department of Health, Bureau of Communicable Disease Control, Hepatitis Unit at 518.473.4439

Facility Information: Inmate's Current Facility Name: \_\_\_\_\_ County: \_\_\_\_\_  
Reporting Individual: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Inmate Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown  
Race:  White  Black  American Indian/Alaska Native  Asian  
 Native Hawaiian/Pacific Islander  Other, specify: \_\_\_\_\_  Unknown  
Sex:  Male  Female Pregnant:  Yes  No  Unknown  
Inmate Country of Birth: \_\_\_\_\_ DIN Number: \_\_\_\_\_ County of Commitment: \_\_\_\_\_  
Please verify diagnosis (*refer to case definitions*):  Acute  Chronic

**Clinical Information/Diagnostic Tests**

Is the patient symptomatic?  Yes  No If yes, onset date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Is the patient jaundiced?  Yes  No If yes, onset date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Anti-HCV (screen)  Positive  Negative Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Anti-HCV (RIBA)  Positive  Negative Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
HCV RNA  Positive  Negative Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
HCV Genotype Result: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Other tests/results: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
ALT (SGPT): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ AST (SGOT): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Lifetime Risk Factors for HCV (Chronic Only)**

	YES	NO	UNKOWN
Receive a blood transfusion prior to 1992?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive an organ transplant prior to 1992?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive clotting factor concentrate produced prior to 1987?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever on long term hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever injected drugs, even if only once or a few times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple lifetime sex partners? If yes, approximate #: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever treated for STDs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever a contact of a person who had hepatitis C virus? If yes, type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household (non-sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever have a needlestick exposure (occupational)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever work in a medical/dental field involving direct contact with human blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a body piercing (not including ear piercing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Copy to inmate medical record.