Hepatitis C Virus Rapid Test Risk Assessment

All risk assessments must be completed in full on all clients who are tested with a rapid screening test. Please fax or print and return this form to Tallahassee. A copy of this form must be kept in the client record. PLEASE PRINT LEGIBLY

Today's Date: _____ County: _____ ☐ CHD ☐ CBO Site #:_____

Clinic/Site (check one): ☐CHD ☐Family Planning ☐Hep 09 ☐STD ☐HIV ☐Jail ☐Outreach ☐Other

DO NOT TEST if client has tested positive for hepatitis C. Complete confirmatory blood test for accurate results.

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Date of Birth (mm/dd/yyyy): _____ Age: _____ Sex: ☐Male ☐Female

Race: ☐White ☐Black ☐American Indian/Alaskan Native ☐Asian/Pacific Islander ☐Other ☐Unknown

Ethnicity: ☐Hispanic ☐Non-Hispanic

Do you have any of the following symptoms?

☐ Abdominal Pain ☐ Vomiting ☐ Jaundice (yellowing of eyes or skin)

☐ Loss of appetite ☐ Fever ☐ Nausea ☐ Headache ☐ Diarrhea ☐ None of the Above

History (Check all that apply)

1. Have you ever received a hepatitis vaccine for the following? ☐Hepatitis A? ☐Hepatitis B? ☐No ☐Unknown
2. Have you ever had ☐Hepatitis A? ☐Hepatitis B? ☐No ☐Unknown
3. Have you ever been told that you tested positive for hepatitis C? ☐Yes **(DO NOT TEST)** ☐No ☐Unknown
4. Have you ever received a transfusion of blood or blood components before July 1992? ☐Yes ☐No ☐Unknown
5. Have you ever been employed in the medical/dental field involving direct contact with blood? ☐Yes ☐No Unknown
6. Have you had an invasive procedure in the last year? ☐Yes ☐No ☐Unknown

Risks (Check all that apply)

- ☐ Born 1945-1965
- ☐ Body piercing (in the past year)
- ☐ Tattoos (in the past year)
- ☐ Incarcerated in a jail (in the past year)
- ☐ Incarcerated in a prison (in the past year)
- ☐ Household contact of a person with hepatitis C
- ☐ Injected drugs (in the past year)
- ☐ Needle stick injury
- ☐ Snorting drugs
- ☐ Multiple sexual partners (in the past year) ___2-5 ___>5___Unknown
- ☐ Sexually transmitted disease
- ☐ Long term sexual partner with hepatitis C
- ☐ Shared needles for any reason (in the past year)

Rapid Test Information

Rapid Test Kit Lot Number: _____ Rapid Test Kit Expiration Date: _____

Time Test Began: _____ Time Test Read: _____

Test Results: ☐Reactive ☐Non-reactive Results Given? ☐Yes ☐No ☐Refused Test

Linked to Care: ☐Yes ☐No Counselor Name: _____

Return completed forms by **fax** to 850-401-6480, ***or***
Return completed forms by mail to:

Florida Department of Health
Viral Hepatitis and Outbreak Response Section
4025 Esplanade Way, Cubicle 330.02
Tallahassee, FL 32399
Attn: Rapid HCV Testing Program

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