HCV Screening/Initial Presentation

MOLINA CASE: ☐ Yes ☐ No

Presentation Date: ____/____/_____ Site: _____ Clinician: _____

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any UNM-HSC clinician and any patient whose case is being presented in a Project ECHO setting. ***Always use ECHO ID# when presenting a patient in clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws.***

Screening Encounter Date: ____/____/_____ *(required)*

General Information/Demographics

Patient Name/ECHO ID:		**Date of Birth:**	_____/_____/_____
Gender:	☐ Male ☐ Female		
Ethnicity – Hispanic or Latino:	☐Yes ☐No		
Race:	☐ American Indian, Alaska Native ☐ Asian ☐ Black, African American ☐ Native Hawaiian, Pacific Islander ☐ White		

Suspected Route of HCV Transmission (Check all that apply)

Suspected Route of Transmission	Yes	Description
Current or former injection drug user (even once)	☐	If yes, Injection Drug Use in the last 12 months? ☐Yes ☐No
Recipient of clotting factor concentrates made before 1987	☐	
Blood transfusion or solid organ transplant before July 1992	☐	
Needlestick injury in healthcare setting	☐	
Birth to an HCV-infected mother	☐	
Sex with an HCV infected person	☐	
Sharing contaminated personal items, such as razors or tooth brushes with an HCV infected person	☐	
Non-professional tattoo	☐	
Unknown	☐	

Medical Diagnoses (Check all that apply)

Liver Related History (select all that apply)	Yes	Description/Comments
HCV	☐	Year of diagnosis: _____
Cirrhosis	☐	Any evidence of decompensation? ☐ Ascites ☐ Hepatic encephalopathy ☐ Variceal bleed
Previous HCV Treatment	☐	Year: _____ Drug Regimen: _____ Duration of treatment in weeks: _____
Liver Biopsy	☐	Year: _____ Results: _____

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Medical Diagnoses (select all that apply)	Yes	Description/Comments
Asthma	☐	
Auto Immune Disease	☐	Type of disease: _____
Brain Injury	☐	
Cancer	☐	Year: _____ Type of Cancer: _____
Chronic Pain	☐	
COPD	☐	
Coronary Artery Disease	☐	
Cryoglobulinemia	☐	
Diabetes Mellitus	☐	
Hepatitis B, chronic	☐	
HIV	☐	
Hypertension	☐	
Peripheral Neuropathy	☐	
Renal Insufficiency	☐	
Seizure Disorder	☐	
Solid Organ Transplant	☐	Year of transplant: _____ Organ transplanted: _____

Hepatitis Vaccinations

Vaccination	Yes	No	Description/Comments
Did patient receive hepatitis A vaccination series?	☐	☐	REMINDER: Patients with hepatitis C need to be vaccinated for both hepatitis A and B.
Did patient receive hepatitis B vaccination series?	☐	☐	

Psychiatric Diagnosis

Psychiatric Diagnosis	Yes	Description
Depression	☐	
Anxiety	☐	If yes, is patient on medication for anxiety? ☐Yes ☐No
Mania/Hypomania	☐	If yes, is patient on medication for Mania/Hypomania? ☐Yes ☐No

Survey Scores

PHQ-9 Score:		Date of survey: ____/____/_____

Substance Use History

Substance Use History	Yes	No	Description/Comments
Does patient currently drink alcohol?	☐	☐	If no, has the patient ever had a drinking problem? ☐Yes ☐No Date of last drink: ____/____/_____

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Does patient currently use drugs other than alcohol?	☐	☐	If yes, check all that apply: ☐ Opiates ☐ Stimulants (cocaine, amphetamine, etc.) ☐ Benzodiazepines ☐ Marijuana
Does patient smoke cigarettes?	☐	☐	

Current Medications: (Please include dosage)

Medication Name	Dosage	Frequency

Medication Name	Dosage	Frequency

Body Mass Index

Height:		☐Centimeters	☐Inches
Weight:		☐Kilograms	☐ Pounds
BMI:			

Laboratory

Basic Laboratories			
Date of Lab Draw:	___/_____/_____		
WBC		INR	
ANC		Albumin	
HGB		ALT	
HCT		AST	
Platelets		Alk Phos	
Creatinine		T. Bili	
Glucose		Direct Bili	
Protime		Total Prot	

Other Essential Results	Date	Result
Fe	___/___/_____	
TIBC	___/___/_____	
Ferritin	___/___/_____	
Vitamin D 25-OH	___/___/_____	
AFP	___/___/_____	
HIV Ab	___/___/_____	
HCV Genotype	___/___/_____	
HCV Viral Load	___/___/_____	
Other: _____	___/___/_____	

APRI= 100 X $\frac{\text{AST/40}}{\text{Plt}}$

APRI =	

For Clinical Calculators (APRI, MELD, etc.), visit:
http://www.hepatitisc.uw.edu/page/clinical-calculators/meld

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