FAIRFAX COUNTY HEALTH DEPARTMENT

Hepatitis Screening Program – STD Clinic

Name:_____ Date: _____

The Centers for Disease Control and Prevention (CDC) strongly recommend that persons in some categories be tested for Hepatitis C, so that important medical care and preventative measures can occur to maintain health and prevent the spread of this virus. You may qualify for free Hepatitis C and B testing through this clinic.
The Virginia Department of Health (VDH) provides funding for this Hepatitis C and B testing – your results and category(s) of risk that qualify you for this testing are sent to VDH.

I want / I Do Not want ***(circle one)*** to be screened today to see if I qualify for the free Hepatitis C & B testing

_____ _____

Signature of Client Date

I. Hepatitis C and B Lab Testing Programs – Qualifying Risk Factors:

If you want to be screened today, please complete questions 1 - 8

1.	Have you ever injected drugs not prescribed by a doctor? If yes, have you injected drugs in the past 12 months?	☐ Yes ☐ Yes	☐ No ☐ No
2.	Are you HIV positive? (*Note:* annual Hep C testing recommended if HIV+)	☐ Yes	☐ No
3.	Have you had a transfusion of blood or blood products before 1993?	☐ Yes	☐ No
4.	Have you ever been diagnosed with hemophilia?	☐ Yes	☐ No
5.	Have you ever had sex with and/or living with someone who has Hepatitis C?	☐ Yes	☐ No
6.	Have you ever had sex with and/or living with someone who has Hepatitis B?	☐ Yes	☐ No
7.	Are you currently receiving dialysis for kidney problems?	☐ Yes	☐ No
8.	*Men only:* Have you ever had sex with another man?	☐ Yes	☐ No

If yes to one or more questions above, you are eligible for free Hep C & B testing. If no to all you do not qualify.

II. Hepatitis B and Hepatitis A Vaccine History

9.	Have you ever had Hepatitis B Vaccine? Series? (check all that apply) Dose 1 ☐ Dose 2 ☐ Dose 3 ☐	☐ Yes	☐ No
10.	Have you ever had Hepatitis A Vaccine? Series? (check all that apply) Dose 1 ☐ Dose 2 ☐	☐ Yes	☐ No

III. *Clinic Use Only* - Services Provided ***If unimmunized:* Counseling**

Referred to private provider, Walk-in or RN Clinic (vaccine charges may apply)? ☐ Yes _____ (date) ☐ N/A

Lab Sample for Hep B & C drawn with pre-test counseling? ☐ Yes Date: _____ ☐ No

Note: if immunized with Hepatitis B Vaccine, no need to accomplish Hepatitis B lab testing unless risk exposure occurred prior to vaccination

Note: annual screening for Hepatitis C is recommended for those who are HIV positive

_____ _____

Clinician Signature Date

LABEL

Client's Name:_____

Client's PIN:_____

Date of Birth: _____

IV. BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY FOR REPORTING TO VDH:

Hepatitis Vaccine History	
☐ Hep A	☐ Hep A&B
☐ Hep B	☐ Unknown

Hepatitis B and/or C Test Results:

HEP B			
HBsAg	☐ Pos	☐ Neg	Collection Date:
HB c Ab	☐ Pos	☐ Neg	Collection Date:
HB s Ab	☐ Pos	☐ Neg	Collection Date:

HEP C			
Rapid	☐ Pos	☐ Neg	Collection Date:
HCV Ab	☐ Pos	☐ Neg	Collection Date:
HCV Qual	☐ Pos	☐ Neg	Collection Date:

Called back for results:
Hep C & B test (if applicable) results provided with counseling? ☐ Yes ☐ No Date: _____

If yes, and test results positive, referred to Medical Care? ☐ Yes ☐ No Where: _____

Health Insurance: ☐ Yes ☐ No

☐ Did not call back for results

_____ _____
Clinician Signature Date

_____ _____
Interpreter Name Date

Screening Site (circle one): ADO JWHC HRDO MVDO SDO

LABEL
Client's Name:_____
Client's PIN:_____
Date of Birth: _____

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Fax completed form to Kelly Square (KS) at 703-653-1347, Attn: STD Hepatitis B-C Program