FAIRFAX COUNTY HEALTH DEPARTMENT

Hepatitis Screening Program – STI Clinic

Name:_____ Date: Click or tap to choose

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 Hepatitis C and/or B testing through this clinic.

I. Hepatitis C and B Lab Testing Programs – Qualifying Risk Factors: to be screened today, please answer all questions

If yes to the following test for Hepatitis B and C			Notes
Have you ever injected drugs not prescribed by a doctor (Person Who Injects Drugs – PWID/intravenous drug use - IDU)?	☐ Yes	☐ No	
Are you HIV positive? (*Note:* annual Hep C testing recommended if HIV+)	☐ Yes	☐ No	
Men only: Are you a man who has sex with men?	☐ Yes	☐ No	
Have you stayed in jail or prison? (i.e. Have you ever been incarcerated?)	☐ Yes	☐ No	
Have you had hepatitis, liver disease, or elevated liver enzymes (ALT/AST)?	☐ Yes	☐ No	
Have you ever had sex for money, drugs, or other things you needed?	☐ Yes	☐ No	
Were you born to a mother infected with Hep B or C? (Test for whichever is indicated – B or C or both)	☐ Yes	☐ No	
If yes to any of the following test for Hepatitis B only			**Notes**
Country of birth (if not US, write-in name of country)	☐ US	Other: _____	
Have you ever had sex with and/or living with someone who has Hep B?	☐ Yes	☐ No	
Have you ever had sex with someone who has sex for money, etc.?	☐ Yes	☐ No	
Have you had a medical condition requiring immunosuppressive therapy?	☐ Yes	☐ No	
If yes to any of the following, test for Hepatitis C only			**Notes**
Have you had a transfusion of blood, before 1992?	☐ Yes	☐ No	
Have you had clotting factor concentrates produced before 1987?	☐ Yes	☐ No	
Were you born between 1945-1965?	☐ Yes	☐ No	
Have you ever had or are you currently having dialysis?	☐ Yes	☐ No	
Have you ever gotten a tattoo or piercing outside of a licensed parlor?	☐ Yes	☐ No	
Have you ever snorted or inhaled drugs? Or have you ever shared drug equipment?	☐ Yes	☐ No	
Have you ever had sex with someone who has Hepatitis C?	☐ Yes	☐ No	
Were you referred here because of a positive (reactive) rapid Hep C test?	☐ Yes	☐ No	

If no to all you do not qualify for Hepatitis B and/or C testing. If yes, you qualify for Hep B and/or C testing, which can be repeated if 'yes' indicates a new qualifying risk since your last screening test or if greater than one year has passed since your last screening test.

The Virginia Department of Health (VDH) provides funding for this Hepatitis C and B testing, though your health insurance will be billed if you have health insurance and elect to use that insurance. Your test results and category(s) of risk that qualify you for this testing are sent to VDH.

☐ I want ***OR*** ☐ I Do Not want ***(check one)*** to be tested today for Hepatitis C &/or B, if I qualify for this grant funded testing.

_____ Click or tap to enter a date.

Signature of Client Date

II. Hepatitis B and Hepatitis A Vaccine History

Have you ever had Hepatitis B Vaccine? Series? (check all that apply) Dose 1 ☐ Dose 2 ☐ Dose 3 ☐	☐ Yes	☐No
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** ☐ Yes _____ (date) ☐ N/A

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

Lab Sample for Hep B &/or C drawn with pre-test counseling? ☐ Yes Date: _____Hep B Hep C (circle) ☐ 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

_____

LABEL

Client's Name:_____

Client's PIN:_____

Date of Birth: _____

Clinician Signature Date

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

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:
HBV IgM	☐ Pos	☐ Neg	Collection Date:

HEP C			
HCV Ab	☐ Pos	☐ Neg	Collection Date:
HCV RNA	☐ Pos	☐ Neg	Collection Date:

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

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

☐ Did not call back for results

_____ _____
Clinician Signature Date

_____ _____
Interpreter Name, if applicable Date

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

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

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Scan completed form to designated M Drive folder