Health Care Provider (HCP) Hepatitis C Virus (HCV) Surveillance Form

Please complete Sections A and B below to report necessary information to the Medical Officer of Health at Toronto Public Health (as required under the *Health Protection and Promotion Act, RSO 1990 c.H.7*) as soon as you receive a positive HCV result and/or make a clinical diagnosis. This fillable PDF form can be completed digitally or in print and be emailed to cdcBloodborne@toronto.ca. Blank copies of this form are available on our website: Toronto.ca/hepatitis

Patient Information

First Name: _____

Last Name: _____

DOB: _____

Age: _____

iPHIS # (TPH Staff Only): _____

HCP INFORMATION

Name: _____

Signature: _____

Date: _____

CDI Information

Name: _____

Email: CDCBloodborne@toronto.ca

Phone: 416-338-8400
(leave a voicemail on our intake line)

Work Hours: 0830-1630hrs, Mon-Fri

SECTION A: Case Information

1. Reasons for HCV Antibody (Anti-HCV/HCV Ab) testing (please check all that apply):

- ☐ Increased risk identified (please select the risk(s) identified in question 2)
- ☐ Routine Screening (inc. pre-employment screening or screening for those with continued exposure)
- ☐ Prenatal, EDD: _____ (DD/MM/YYYY)
- ☐ Presented with symptoms
- ☐ Presented with evidence of liver disease (e.g., elevated ALT, physical exam)
- ☐ Other, please specify: _____

_____

_____

2. Risk Factors (please check all that apply):

- ☐ Hepatitis B or HIV infection
- ☐ Current or past drug use or client of Opioid Agonist Therapy Clinic
- ☐ Incarceration
- ☐ Born or ☐ lived in an endemic country (please specify country and year came to Canada: _____)
- ☐ Patient born to a birthing parent with HCV infection
- ☐ Household or caregiver contact with HCV infection
- ☐ Sexual/intimate partner contact with HCV infection
- ☐ Occupational exposure (e.g., healthcare worker)
- ☐ Suspected exposure in aesthetic/body modification, medical, dental, or other setting within the last two years.

Please specify type and location of exposure setting:

Type: _____

Location of setting: _____ (City, Country)

- ☐ Other, please specify: _____

Information collected on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c.H.7, Ontario Regulation 569/90 - Reports, and Ontario Regulation 559/91 - Specification of Reportable Diseases. It is used to investigate cases of hepatitis B infection, for patient care, to manage potential risks to others or to the population at large, and for resource planning and quality assurance. Questions regarding this collection should be directed to Toronto Public Health's Bloodborne Disease-Infection Prevention and Control Program by phone at 416-338-7600.

3. Type of HCV Ab testing:

- ☐ Venous sample
- ☐ Dried blood spot sample
- ☐ Point of care Ab test
- ☐ Unknown

4. Type of HCV RNA testing (if completed):

- ☐ Venous sample
- ☐ Dried blood spot sample
- ☐ Point of care RNA test
- ☐ Unknown

5. Has the patient cleared an HCV infection before?

- ☐ Yes, they were previously treated
- ☐ Yes, they spontaneously cleared infection
- ☐ No
- ☐ Did not ask
- ☐ Unknown

6. Was the patient previously aware of their current HCV status?

- ☐ Yes
- ☐ No
- ☐ Did not ask
- ☐ Unknown

7. Is the patient deceased?

- ☐ No
- ☐ Yes, Date of death: _____ (DD/MM/YYYY);
  Cause of death, if known: _____
- ☐ Yes, Patient deceased, details unknown

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SECTION B: Counselling and Clinical Follow Up

Please confirm completion of all steps by checking the boxes below or indicate if the patient has been lost to follow up:

☐ **Patient has been lost to follow up**

Clinician's Next Step	Completed	Planning to do	Will not complete	Provide more information
Notified patient of test results and provided counselling on preventing further transmission and educating contacts (TPH HCV quick reference guide; CATIE HCV resources; TPH Hepatitis Information for Health Professionals).	☐	☐	☐	
Ordered HCV RNA testing (if not already completed).	☐	☐	☐	
Prescribed HCV treatment (if HCV RNA+). Note: • Non-specialists can receive CME accredited training in HCV management.	☐	☐	☐	Treatment start date: _____ (DD/MM/YYYY)
Referred patient for HCV treatment (if HCV RNA+). Note: • Find a provider to treat your patient at: Ocean Healthmap. Is your patient uninsured? Find information about coverage for uninsured patients at: CATIE	☐	☐	☐	Name of provider: _____ Treatment start date: _____ (DD/MM/YYYY)
Ordered FREE HAV and HBV vaccines for patient using TPH's Vaccine Order Form.	☐	☐	☐	Patient has received complete series of: ☐ HAV vaccine ☐ HBV vaccine

Reminders

1. Order liver and renal tests, calculate FIB-4 and/or APRI scores, and test for the following infectious disease markers, to assess treatment or prior to referral to treatment:
   - HAV immune status (HAV IgG)
   - HBV immune status (anti-HBs/HBsAb) and chronic infection (HBsAg, anti-HBc/HBcAb)
   - HIV
   - CBC
   - ALT
   - AST
   - INR
   - Creatinine
   - Albumin
   - Na
   - Bili

   Note: Testing from Public Health Ontario Laboratory (requisition) are covered for anyone in Ontario, including uninsured patients (Test Information Index).
2. Order HCV RNA testing for the patient at least 12 weeks after treatment completion to confirm sustained virologic response.

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