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 e-mail 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 NAME:_____

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

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 ☐Haitian

Do you have any of the following symptoms?

☐ Abdominal Pain ☐ Vomiting ☐ Jaundice (yellowing of eyes or skin)
☐ Loss of appetite ☐ Fever ☐ Nausea ☐ Headache ☐ Diarrhe

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? ☐Hepatitis C? ☐No ☐Unknown
3. Have you ever been told that you tested positive for hepatitis C? ☐Yes ☐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
7. 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

Return completed forms by fax to: 850-414-8103, ***or***
Return completed forms by email by clicking on the "Submit Form" button above, ***or***
Return completed forms by mail to:

HIV/AIDS Section
4025 Esplanade Way
Tallahassee, FL 32399
Attn: Rapid Testing Data, Room 325F