# FAIRFAX COUNTY HEALTH DEPARTMENT
## Hepatitis Screening Program – STI 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 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** |
| If you are 18 years and older, have you ever been tested for hepatitis C? (test once in lifetime) | ☐ Yes | ☐ No | |
| Have you had a transfusion of blood or organ transplant before 1992? | ☐ Yes | ☐ No | |
| Have you had clotting factor concentrates produced before 1987? | ☐ 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 | |
| Have you ever had a needle stick injury? If yes, where did this occur? | ☐ 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 to be tested today for Hepatitis C &/or B

□ I Do Not want to be tested today for Hepatitis C &/or B

_____ _____

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 if you 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 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**