



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

Do you have any of the following symptoms?

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

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
6. 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 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