West Virginia Department of Health
Bureau for Public Health
Office of Epidemiology and Prevention Services
Division of STD, HIV, Hepatitis and Tuberculosis
(304) 558-2195

Rapid Hepatitis C Result Report Form

Report Date:	___ ___ / ___ ___ / ___ ___

Client Name and Contact Information

First and Last Name:		Birthdate:	__ __ / __ __ / __ __	Age:	
Street Name:					
City/State/Zip/County:					
Home Phone:		Cell Phone:		Email:	

Ethnicity:	Race: *(select all that apply)*	Assigned Sex at Birth:
☐Hispanic or Latino ☐Not Hispanic or Latino ☐Don't Know ☐Declined to Answer	☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian/Pacific Islander ☐White ☐Not Specified ☐Declined to Answer ☐Don't Know ☐Other _____	☐Male ☐Female ☐Other _____

Client Medical Information

Does the patient report a history of hepatitis C?	Does the patient currently have symptoms?	Has the patient been tested in the last 12 months?	Is the patient currently pregnant?	Has this patient been linked to care?	Has a blood draw been done to verify this result?	Has the patient been notified of their test result?
☐Yes ☐No	☐Yes ☐No *If yes, symptoms & onset:*	☐Yes ☐No *If yes, result & date:*	☐Yes ☐No *If yes, weeks' gestation:*	☐Yes ☐No *If yes, date & location:*	☐Yes ☐No	☐Yes ☐No

Test Information

Test Type:	Date:	Lot #:	Expiration Date:	Test Times:	Rapid Result:
☐Rapid Antibody ☐Rapid RNA ☐Other	__ __ / __ __ / __ __	_____	__ __ / __ __ / __ __	Test Start Time: _____ Test Read Time: _____	☐Reactive ☐Non-reactive

Facility Information

Reporting Facility:			
Reporting Facility Address:		Reporting Facility Phone Number:	
Tester Name:		Tester Signature:	

Please report all viral hepatitis test results to:
Viral Hepatitis Surveillance Unit
Fax: (304) 558-8736