

Indian Country Hepatitis C Initial Case Presentation Form

Presentation Date: _____ Site: _____ Clinician: _____

General Information/Demographics

Patient ECHO ID:	Age:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity:
Insurance: <input type="checkbox"/> None <input type="checkbox"/> Commercial Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medicaid, MCO (if in NM, please specify: <input type="checkbox"/> Presbyterian <input type="checkbox"/> BCBS <input type="checkbox"/> Western Sky <input type="checkbox"/> Unknown)			

Liver Related History	<input type="checkbox"/> Cirrhosis	Any evidence of clinical decompensation? <input type="checkbox"/> Ascites <input type="checkbox"/> Hepatic Encephalopathy <input type="checkbox"/> Variceal Bleed
	<input type="checkbox"/> Previous HCV Treatment	Year: _____ Drug Regimen: _____ Duration of Treatment: _____
	<input type="checkbox"/> Hepatocellular Carcinoma	Year of Diagnosis: _____

Medical Diagnoses	<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Seizure Disorder	
	<input type="checkbox"/> Hepatitis B, Chronic	<input type="checkbox"/> Solid Organ Transplant --- Year: _____ Organ: _____
	<input type="checkbox"/> HIV	<input type="checkbox"/> Rheumatoid Arthritis
	<input type="checkbox"/> Other Relevant Diagnoses: _____	

Psychiatric Diagnoses	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other: _____
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Depression Screening: (If available)	<input type="checkbox"/> PHQ 9: _____ <input type="checkbox"/> PHQ 2: _____ <input type="checkbox"/> Other: _____
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Substance Use History	Does the person have a substance use disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, <input type="checkbox"/> Alcohol <input type="checkbox"/> Opiates <input type="checkbox"/> Stimulants <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Marijuana <input type="checkbox"/> Other: _____ If yes, date of last use (for each): _____	
	History of injecting drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of last injection drug use: _____

Current Medications:

Medication Name	Dosage	Frequency

Medication Name	Dosage	Frequency

Current Method of Birth Control: _____

If oral contraceptive, does it contain ethinyl estradiol? Yes No

To submit a case for presentation, please send completed forms to:

NPAIHB ECHO Fax: 888.462.3246

Email: dstephens@npaihb.org

Body Mass Index	Height:	Weight:	BMI:
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Hepatitis Vaccinations and Labs	Hepatitis A total or IgG antibody: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	If needed has vaccination been started? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hepatitis B surface antibody (anti-HBs): <input type="checkbox"/> Positive <input type="checkbox"/> Negative	If needed has vaccination been started? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hepatitis B core antibody (anti-HBc): <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B surface antigen (HBsAg): <input type="checkbox"/> Positive <input type="checkbox"/> Negative	

Laboratory

Basic Labs	Date	Results
WBC		
HGB		
HCT		
Platelets		
Creatinine		
GFR		
Glucose		
Prottime/INR		

Basic Labs	Date	Results
Total Prot		
Albumin		
Alk Phos		
AST		
ALT		
T. Bili		
Direct Bili		

Other Labs	Date	Results
Vitamin D		
Fe		
TIBC		
Ferritin		
AFP		
HIV Ab		
HCV RNA		
HCV Genotype		

Other Pertinent Labs (e.g. serum fibrosis)	Date	Results

Fibrosis Score	Results
APRI	
FIB-4	
For cirrhotic patients only	
MELD	
Child-Pugh	

For clinical calculators: hepatitisc.uw.edu/page/clinical-calculators/apri

Please list any imaging or transient elastography results, if applicable (e.g. ultrasound, fibroscan, etc.):

Please list any additional pertinent information about the patient:

What is the primary question you have regarding this patient?

PLEASE NOTE that case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in this clinical setting. Always use Patient ID# when presenting a patient in clinic. Sharing patient name, initials or other identifying information violates HIPAA privacy laws.

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