Northwestern Health Unit
www.nwhu.on.ca

Northwestern Health Unit Control of Infectious Diseases
Hepatitis C Public Health Case Investigation

Please return this completed form to the Northwestern Health Unit by fax at 807-468-3813

DATE: _____ ☐ **Internal Case**

Client demographics: Please confirm current address, telephone, and email, or affix label	
Name:	Telephone:
Gender:	Email:
DOB (YY/MM/DD):	Address, including postal code:
Health Card #:	

Is client First Nations? No ☐ Yes ☐
If yes, do they live in a First Nations community? No ☐ Yes ☐ Specify which community: _____

Reason For Testing				
☐ Routine	☐ Contact Tracing	☐ Prenatal	☐ Symptoms	☐ Other: _____
Has the client testing positive in the past for Hep C? ☐ No ☐ Yes				

If YES, when?	If YES, where?
Hep C antibody testing Date:	Result:
Hep C genotype testing Date:	Result:
Hep C RNA viral load testing Date:	Results:
Most recent antigen test	
Hep A Date:	Result:
Hep B Date:	Result:

Symptoms (select all that apply)	**Start date**
☐ Asymptomatic	N/A
☐ Anorexia	
☐ Fatigue	
☐ Abdominal discomfort	
☐ Joint pain	
☐ Fever	
☐ Jaundice	
☐ Other, please specify:	

Other STBBI screening	**Results**
☐ Chlamydia	
☐ Gonorrhea	
☐ HIV	
☐ Hepatitis B	
☐ Syphilis	
☐ Other:	

Last non-reactive Hep C antibody test	
Date**:**	Location:

November 2024

Client Name: _____ DOB: _____

Counselling	
Client is aware of diagnosis: ☐ Yes ☐ No	Treatment options discussed: ☐ Yes ☐ No
Client has been advised of:	
☐ Modes of Hep C transmission (blood to blood)	☐ Risk reduction strategies to prevent transmission including use of condoms and harm reduction services
☐ Natural progression of Hep C infection and the importance of medical follow up	☐ Eligibility for publicly funded high-risk vaccines
☐ Importance of notifying, testing, and following up with contacts (household, sexual, drug sharing partners)	☐ Do not donate semen, organs, blood, blood products
☐ Inform care team of diagnosis including any provider that may pierce the skin	☐ Do not share hygiene items

Medical Risk Factors (select all that apply):

- ☐ Received blood or blood products
  When: _____
  Where: _____
- ☐ Co-diagnosis/co-infection with existing STI
  Specify: _____
- ☐ HIV Status
- ☐ Received organ/tissue transplant or donor insemination
  When: _____
  Where: _____
- ☐ Born to a case or carrier
- ☐ Repeat STI
- ☐ Other: _____
- ☐ Invasive surgical/dental/ocular procedure
  When: _____
  Where: _____
- ☐ Pregnant
- ☐ Unknown
- ☐ No to all

Exposure Risk Factors (select all that apply):

- ☐ Bathhouse
- ☐ Blood exposure through shared accident
- ☐ Correctional facility
- ☐ Under-housed/homeless
- ☐ Other: _____
- ☐ Occupational exposure to potentially contaminated body fluids
- ☐ Electrolysis and acupuncture
- ☐ Tattoo and piercing
- ☐ Other personal services setting
  Specify: _____
- ☐ Unknown
- ☐ Other social venue
  Specify: _____
- ☐ Travel:
  Specify: _____
- ☐ Shared personal care items (e.g., toothbrush, razor, fingernail clippers)
- ☐ No to all

Behavioural Risk Factors (select all that apply):

- ☐ Anonymous sex
- ☐ Consumed breastmilk
- ☐ Sex with opposite sex
- ☐ Sex with same sex
- ☐ Sex with transgender person
- ☐ Sex for drugs/food/shelter/survival
- ☐ Fighting/biting/torture/blood brother
- ☐ Strategic positioning
- ☐ Contact lived in or visited country where Hep C is endemic
  Specify: _____
- ☐ No condom use
- ☐ Condom breakage
- ☐ Sex trade worker
- ☐ Sex with sex trade worker
- ☐ Contact is HIV positive
- ☐ Serosorting
- ☐ Judgement impaired by drugs/alcohol
  Specify: _____
- ☐ Contact visiting from outside province or country
  Specify: _____
- ☐ New partner in last 2 months
- ☐ More than 1 partner in last 6 months
- ☐ Inhalation drug use
- ☐ Injection drug use
- ☐ Shared needles
- ☐ Shared other drug equipment
- ☐ Shared sex toys
- ☐ Met contact through internet
- ☐ Unknown
- ☐ Other: _____
- ☐ No to all

Client Name: _____ DOB: _____

In all cases, clients are to be advised to notify all contacts. *Contacts are defined as household members, sexual contacts, persons who shared personal care items (toothbrush, razor, needles) persons exposed to blood or body fluids, infants born to HCV+ mothers.*	
☐ **Healthcare provider to notify partner(s)** ☐ **This person is a contact of a case and is being treated.**	☐ **Client has been advised they will be contacted by public health to discuss contact notification**
LIST PARTNER INFO HERE (NAME & CONTACT INFO)	LIST PARTNER INFO HERE (NAME & CONTACT INFO)
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Has case been referred to a specialist or health care professional experienced with Hep C for ongoing follow up? ☐ Yes ☐ No		
Name:		
Facility:		
Telephone #:	ext:	Fax #:

Physician/NP/Midwife completing form:		
Name:		
Facility:		
Telephone #:	ext:	Fax #:

Thank you for your assistance.

Kit Young Hoon, MBBS, MPH, MSC, FRCPC
Medical Officer of Health

Enter name and designation