

**FAIRFAX COUNTY HEALTH DEPARTMENT  
Hepatitis Screening Program – STD 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 free Hepatitis C and B testing through this clinic.

The Virginia Department of Health (VDH) provides funding for this Hepatitis C and B testing – your results and category(s) of risk that qualify you for this testing are sent to VDH.

I want / I Do Not want (**circle one**) to be screened today to see if I qualify for the free Hepatitis C & B testing

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

**I. Hepatitis C and B Lab Testing Programs – Qualifying Risk Factors:**

**If you want to be screened today, please complete questions 1 - 8**

1.	Have you ever injected drugs not prescribed by a doctor? If yes, have you injected drugs in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
2.	Are you HIV positive? ( <i>Note:</i> annual Hep C testing recommended if HIV+)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you had a transfusion of blood or blood products before 1993?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Have you ever been diagnosed with hemophilia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Have you ever had sex with and/or living with someone who has Hepatitis C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you ever had sex with and/or living with someone who has Hepatitis B?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Are you currently receiving dialysis for kidney problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	<i>Men only:</i> Have you ever had sex with another man?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*If yes to one or more questions above, you are eligible for free Hep C & B testing. If no to all you do not qualify.*

**II. Hepatitis B and Hepatitis A Vaccine History**

9.	Have you ever had Hepatitis B Vaccine? Series? (check all that apply) Dose 1 <input type="checkbox"/> Dose 2 <input type="checkbox"/> Dose 3 <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Have you ever had Hepatitis A Vaccine? Series? (check all that apply) Dose 1 <input type="checkbox"/> Dose 2 <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**III. Clinic Use Only - Services Provided**

*If unimmunized: Counseling*

Referred to private provider, Walk-in or RN Clinic (vaccine charges may apply)?  Yes \_\_\_\_\_ (date)  N/A

Lab Sample for Hep B & C drawn with pre-test counseling?  Yes Date: \_\_\_\_\_  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 for those who are HIV positive

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

<b>LABEL</b>
Client's Name: _____
Client's PIN: _____
Date of Birth: _____

**IV. BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY FOR REPORTING TO VDH:**

Hepatitis Vaccine History	
<input type="checkbox"/> Hep A	<input type="checkbox"/> Hep A&B
<input type="checkbox"/> Hep B	<input type="checkbox"/> Unknown

**Hepatitis B and/or C Test Results:**

HEP B			
HBsAg	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	Collection Date:
HB c Ab	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	Collection Date:
HB s Ab	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	Collection Date:

HEP C			
Rapid	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	Collection Date:
HCV Ab	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	Collection Date:
HCV Qual	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg	Collection Date:

Called back for results:  
 Hep C & B test (if applicable) results provided with counseling?  Yes  No Date: \_\_\_\_\_  
 If yes, and test results positive, referred to Medical Care?  Yes  No Where: \_\_\_\_\_  
 Health Insurance:  Yes  No

Did not call back for results

\_\_\_\_\_  
 Clinician Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Interpreter Name

\_\_\_\_\_  
 Date

Screening Site (circle one):    ADO                      JWHC                      HRDO                      MVDO                      SDO

LABEL	
Client's Name:	_____
Client's PIN:	_____
Date of Birth:	_____

FHD-CL-S-29 Rev. 1/4/16 (P)

**Fax completed form to Kelly Square (KS) at 703-653-1347, Attn: STD Hepatitis B-C Program**

**HEPATITIS SCREENING PROGRAM – STD CLINIC**  
**INSTRUCTIONS TO COMPLETE SCREENING FORM**

**PURPOSE:** Used to document the offer of and, if the offer is accepted, the screening of STD clients who may qualify for VDH grant-funded Hepatitis C & B serology testing. Clients may be screened and, if they qualify, offered testing each time they attend clinic – no limit.

**COMPLETION:**

**I: Hepatitis C and B Lab Testing Programs – Qualifying Risk Factors**

Section I is completed by STD clients and reviewed with the client by the Public Health Nurse or Community Health Specialist prior to examination/treatment.

- If clients opts-into screening, by circling ‘I want to be screened...’ and meets one or more qualifying risk factors, draw serology for Hep C & B testing (if unimmunized or risk exposure occurred prior to immunization) per Procedural Memorandum ‘Hepatitis B and Hepatitis C Laboratory Testing for STD Clients’ – sign and date that labs were drawn in spaces designated for this documentation (in section III. **Clinic Use Only Services Provided**).

Note: annual screening for Hepatitis C is recommended for those who are HIV positive

**II: Hepatitis Vaccination History**

- Document client-reported Hepatitis B and A vaccine history
- Refer unvaccinated clients to private providers, FCHD walk-in or RN clinic(s) to acquire vaccine(s) – charges for vaccine may be involved.

**III: Clinic Use Only – Services Provided**

- Check yes and date, if client is referred for Hepatitis B and / or A vaccine, or N/A
- Check yes and date or no re: whether a lab sample for Hep B and / or C was drawn with pre-test counseling provided

**IV. BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY FOR REPORTING TO VDH:**

This section is completed to comply with reporting requirements associated with lab testing funding provided by and reported to VDH:

- Hep Vaccine Hx: Select all that apply: Hep A, Hep B, Hep A&B, Unknown note: based on client history.
- Hep B Testing: if drawn, enter the date the test was drawn and specific results from the laboratory results form: check pos **or** neg for all results reported: HB s Ag (Hepatitis B Surface Antigen), HB c Ab (Hepatitis B Core Antibody), HB s Ab (Hepatitis B Surface Antibody)
- Hep C Testing: enter the date the test was drawn and specific results from the laboratory results form: check pos **or** neg for all results reported: - Rapid, HCV Ab (Hepatitis C Antibody, tested by EIA), HCV Qual (Hepatitis C RNA, tested qualitative by NAAT)

**Results Provided:**

Hep C & B (if applicable) Test Results provided with counseling – enter date

If called back for results:

- enter where clients was referred for medical care on the line indicated
- check Yes or No as appropriate re: whether client has health insurance or not

Did not call back for results – check if applicable

**Clinician Signature/Date:** Complete as indicated

**Interpreter Name/Date:** Complete as indicated **note:** If tele-interpreter is used, indicate the interpreter’s number.

Screening site: circle one

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FHD-CL-S-29 (Instructions)