

HEP C PRE-TREATMENT EVALUATION

DATE: _____

Patient's Name / ID: _____ **Provider** _____

Gender: _____ **DOB:** _____ **Race:** _____

Initial Information

Baseline HCV PCR: _____ **Date:** _____

HCV Genotype: _____ **Date:** _____

CD4 Abs / %: _____ / _____ **Date:** _____

HIV PCR: _____ **Date:** _____

AFP: _____ **Date:** _____

Persistent LFT Elevation: YES / NO

Psychiatric History: _____

Illicit Substance / Alcohol Abuse: _____

Current Prescribed Medications:

Med Adherence Hx: Unknown Poor Fair Good Excellent

Concurrent Diagnoses: _____

Hep A
___ Negative
___ Vaccinated
___ Exposed

Hep B
___ Negative
___ Vaccinated
___ Exposed

Last Ocular Exam

(Date)

For Women,
Pregnancy Test

(Date)

Birth Control
Addressed
Y / N

CARDIAC
ISSUES Y / N

If Yes, EKG

(Date)

Conference Recommendations

Biopsy Recommended: YES / NO Date: _____

Biopsy Date: _____ **Biopsy Results:** _____
GRADE STAGE

Liver Imaging Results: _____

Psychiatric Screening Recommended YES / NO Date: _____

Date Completed: _____ **Recommendations:** _____

HCV Treatment Recommended: YES / NO Date: _____

If no, rationale for not recommending treatment: _____

Additional Comments: _____