**Attachment A Hepatitis Test Reporting Form OMB No.0930-0300**

**Exp Date: XX/XX/XXXX**

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| **Provider (grantee) ID no. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | **Date of visit: \_\_\_\_\_\_\_\_\_\_** | |  | | | |  | |
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| **SECTION A: RISK FACTORS**  ❑ Intravenous Drug User Previous Viral Hepatitis C Tests  ❑HIV Positive ❑ No ❑ Yes, Results\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑HCV Positive | | | | | | |  | | | |
| **SECTION B: DEMOGRAPHICS** | | | | | | |
| **Age Ethnicity** | | **Race (Check all that apply)** | | | | |  |  | | |
| ❑ 18-24 yrs ❑Hispanic | | ❑ American Indian | | | | |  |  | |  | |
| ❑ 25-34 yrs ❑Non-Hispanic | | ❑ Asian | | | | |  |  | |  | |
| ❑ 35-44 yrs | | ❑ Black/African American | | | | |  |  | |  | |
| ❑ 45-54 yrs | | ❑ Native Hawaiian/Other Pacific Islander | | | | |  |  | |  | |
| ❑ 55-64 yrs | | ❑ White | | | | |  |  | |  | |
| ❑ 65+ yrs | |  | | | | |  |  |
|  | |  | | | | |  |  |
| **SECTION C: Viral Hepatitis Testing**  **Viral Hepatitis B Results Consent form signed Did Client receive Results of test** | | | | | | |  | |
| ❑ Negative ❑ Positive ❑ Yes  ❑ Referred for Vaccination ❑ No, Reason\_\_\_\_\_\_\_\_\_\_\_    **Viral Hepatitis C Rapid Test Results Confirmatory Test** | | | | ❑ Yes  ❑ No, Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | | | |  | |
| ❑ Negative ❑ Positive ❑ Invalid (Repeat new kit)  ❑ Referred for Treatment | | ❑ YES ❑ No | | | | |  | | | | |  | |
| Test lot number (if available):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | | | | |  | | | | |  | |
|  | |  | | | | |
| **Section D: Service Provided** **(Check all that apply)** **Vaccine Dose Dates Vaccine Lot no.\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |  | | | | | | |
| ❑ Viral Hepatitis A vaccination  ❑ Viral Hepatitis B Vaccination  ❑ Combined Viral Hepatitis A/B Vaccination  ❑ Viral Hepatitis Education  ❑ Viral Hepatitis Counseling | | | #1  #2  #3 | | | |  | | | | | | |
| **Section E: TYPE OF REFERRAL SERVICES (check all that apply)** | | | | | | |  | | | | | | |
| ❑ Viral Hepatitis Confirmatory Testing  ❑ Viral Hepatitis Prevention Counseling  ❑Viral Hepatitis Medical Care/ Evaluation/ Treatment | |  | | | |  |  | | | | | | |  |
| ❑ Comprehensive Risk Counseling & Services  ❑ Other referrals (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | | | |  |  | | | | | | |  |
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Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.  The OMB control number for this project is 0930-0300.  Public reporting burden for this collection of information is estimated to average .05 minutes per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.  Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports

Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.