

NATIONAL REGISTER OF HCV INFECTIONS WITH A KNOWN DATE OF ACQUISITION

REGISTRATION FORM

The national register contains information on HCV infections with a known date of acquisition, and provides a facility for the future monitoring and long term assessment of HCV infection within the UK.

- No patient names will be sent to, or held on, the national HCV register. It is therefore very important that you retain the register number in your records and that you are able to trace the patient from either the register number or the identifier/reference number that you supply on the registration form (Question 1).
- Ethical approval for the register has been obtained from both the Public Health Laboratory Service and the Multi-Centre Research Ethics Committees. There is no formal requirement to gain patient consent.

Enquiries regarding either the HCV national register or completion of the registration form should be directed to:

Dr Helen Harris

Telephone: 0181 200 6868 ext:

E-mail: hharris@

Register number:

Section 1: PATIENT DETAILS *(please insert details or tick boxes as appropriate)*

1. Identifier by which you can recognise the patient in current and future correspondence (e.g. hospital number):

.....

2. Date of birth (dd/mm/yy): / /

3. Sex: Male Female

4. Ethnic group: White Black-Caribbean Black-African Black, other Indian Pakistani
 Bangladeshi Chinese Asian, other Other, please specify:

5. Country of birth:

6. If you are not the patient's GP, please give the name and address of their GP below:

Name:

Address:

.....

7. Has the patient ever injected drugs (even if only once)? Yes No Not known

8. Does the patient have any other known risk factors for HCV infection? Yes No Not known

If yes, please give details:

9. To your knowledge, does the patient have any other significant chronic viral infection? Yes No


If yes, please specify:

10. Does the patient suffer from any other significant medical conditions? Yes No

If yes, please specify:

11. Are you still responsible for the HCV-related care of the patient?

Yes  **PLEASE COMPLETE THE REST OF THE FORM**

No  **PLEASE GIVE THE NAME AND ADDRESS OF THE CLINICIAN NOW RESPONSIBLE FOR THE HCV-RELATED CARE OF THIS PATIENT (AND THEN RETURN THE FORM TO US). PLEASE ALSO ENSURE THAT YOU INSERT YOUR DETAILS AT THE END OF THIS FORM SO THAT WE CAN CONTACT YOU IF WE NEED MORE INFORMATION ABOUT THIS PATIENT. THANK YOU VERY MUCH FOR YOUR HELP.**

Name:

Address:

.....

Section 2: CURRENT CLINICAL STATUS

The next questions ask about the patient's current clinical status. In this context, clinical status is intended to reflect the patient's signs and/or symptoms of liver disease, not their test results. For example, a patient who has abnormal liver function, or whose biopsy indicates liver disease, should be classified as having "no clinical evidence of liver disease" if they have no physical signs or symptoms of liver disease.

1. Has the patient died (please tick box)? Yes No

If yes, please give date of death (dd/mm/yy): / / and cause of death:

If no, does the patient have: No clinical evidence of liver disease  **PLEASE GO TO SECTION 3**

Clinical evidence of liver disease (HCV-related)

Clinical evidence of liver disease (not HCV-related)  Details/cause:

2. Please record any signs and symptoms of liver disease:

Spider naevi Hepatomegaly Splenomegaly Ascites Varices Bleeding varices Liver tumor

Other (please give details):

Section 3: TEST RESULTS

1. Date of last consultation for HCV (dd/mm/yy): / /
2. Has the patient been tested for hepatitis B infection, and if so, what were the results?
- | | | | | |
|-----------|-----------------------------------|-----------------------------------|-------------------------------------|-----------------------------------|
| HBsAg: | Positive <input type="checkbox"/> | Negative <input type="checkbox"/> | Not tested <input type="checkbox"/> | Not sure <input type="checkbox"/> |
| anti-HBc: | Positive <input type="checkbox"/> | Negative <input type="checkbox"/> | Not tested <input type="checkbox"/> | Not sure <input type="checkbox"/> |
3. Has the patient ever had a positive HCV PCR test? Yes No Not tested Not known
- If yes, please give date of first known positive test (dd/mm/yy): / /
4. Date of latest HCV PCR test results (dd/mm/yy): / / Not done Not known
- Results (please tick box): Positive Negative Indeterminant Not known
5. Date of latest liver function tests (dd/mm/yy): / / Not done Not known
- Results (please tick box or enclose copy of report form): Normal Abnormal Not known
- If abnormal, please give results and test ranges: ALT Range AST Range
- Bilirubin Range Albumin Range
6. Date of latest liver biopsy (dd/mm/yy): / / Not done Not known
- Results (please tick box): Normal Abnormal Not known
- If abnormal, please give results (enclose copy of report form, if possible):
- Minimal change Chronic hepatitis Cirrhosis Hepatocellular carcinoma
- Fibrosis score (if known): Scoring system:

Section 4: ANTIVIRAL DRUG TREATMENT

1. Has the patient had any antiviral treatment for HCV? Yes **PLEASE CONTINUE WITH THIS SECTION**
- No **PLEASE GO TO QUESTION 3**

If yes, please insert details of treatment in the table below:

Course	Date started (dd/mm/yy)	Date finished (dd/mm/yy)	Interferon preparation (eg. Intron A®, Wellferon®)	Interferon dosage (mIU)	Interferon schedule (eg. daily, twice weekly)	Other antiviral (eg. Ribavirin)	Dosage of other antiviral (please give units)	Schedule for other antiviral (eg. daily, twice weekly)
A								
B								
C								

2. What was the response to treatment? (please tick only one of the 8 boxes below)

- Late relapse (PCR negative more than 12/12 after treatment but became positive at a later date)
- Long term response (remains PCR negative 12/12 after treatment completed)
- Sustained response (remains PCR negative 6/12 after treatment completed)
- Immediate/initial response (PCR negative <6/12 after treatment completed)
- Transient response (PCR negative during treatment but became positive after treatment)
- No response (never became PCR negative)
- Treatment stopped early (eg. due to side effects)
- Not relevant (still on treatment)

Section 4 continued overleaf

Section 4: ANTIVIRAL DRUG TREATMENT *continued*

3. Has the patient taken part in any antiviral drug trials?

Yes

No

If yes, please give details: Name of trial:

Patient registration/code number: Date of entry: / /

Section 5: CURRENT MANAGEMENT

1. During the last 12 months what care has the patient received for HCV-related illness?

None

Outpatient only

Inpatient (assessment only eg. liver biopsy)

Inpatient (medical care)

If the patient received inpatient (medical care) in the last 12 months for HCV-related illness, please give date and reason for each admission:

Date (dd/mm/yy): / / Reason:

Date (dd/mm/yy): / / Reason:

Date (dd/mm/yy): / / Reason:

Date (dd/mm/yy): / / Reason:

2. What was the patient's alcohol intake at first diagnosis (in units of alcohol/week, if possible)? Not known

3. What is the patient's current alcohol intake (in units of alcohol/week, if possible)? Not known

4. Has the patient ever smoked? Yes No Not known

5. How many cigarettes does the patient currently smoke each day?

None

0-9

10-19

20 or more

Not known

COMMENTS

If you have any comments that you would like to make, please do so in the space below:

Please print your details below so that we can contact you if we need more information about this patient:

Your name:

Date (dd/mm/yy): / / Telephone number:

THANK YOU VERY MUCH FOR YOUR HELP

ALL THE INFORMATION YOU PROVIDE WILL BE TREATED IN CONFIDENCE

PLEASE RETURN THIS FORM TO:

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