VIRAL HEPATITIS CARE FORM

As cited in the Interim Guidelines on the Management of Patients with Hepatitis B and Hepatitis C infection, physicians and health care providers of hepatitis treatment facilites shall submit and report data to the Epidemiology Bureau and their regional, provincial and municipal counterparts. **This form is to be filled-out on the initial and follow-up visit of the client.**
Please write in CAPITAL LETTERS and CHECK the appropriate boxes.

I. VISIT INFORMATION *(Proceed to the Clinical Assessment Section if Case Report Form is recently accomplished)*

Consult date: *(mm/dd/yyyy)* ____ / ____ / _____ **Patient code:**

Client visit type: ☐ Initial ☐ Follow-up **Unique Identifier Code:** ☐☐ - ☐☐ - ☐☐ - ☐☐☐☐☐☐☐☐

Facility name: **Tested positive for:** ☐ Hepatitis B ☐ Hepatitis C

II. CLIENT DATA

Name (full name): _____ First Name _____ Middle Name _____ Last Name _____ Suffix

Sex assigned at birth: ☐ Male ☐ Female **Age in years:** ____ Weight (in kg): ____ Height (in cm): ____

If female, is she **pregnant?** ☐ Yes ☐ No **Nationality:** ☐ Filipino ☐ Other: _____

III. CLINICAL ASSESSEMENT

Signs and symptoms	Result		Laboratory Tests	Date Done	Result	
Jaundice	☐ Yes	☐ No	HBsAg	/ /	☐ Positive	☐ Negative
Coagulopathy	☐ Yes	☐ No	HBeAg	/ /	☐ Positive	☐ Negative
Ascites	☐ Yes	☐ No	Anti-HCV	/ /	☐ Reactive	☐ Non-reactive
Variceal Hemorrhage	☐ Yes	☐ No	HCV-RNA (quali)	/ /	☐ Positive	☐ Negative
Hepatic Encephalopathy	☐ Yes	☐ No	HCV-RNA (quanti)	/ /	_____	IU/mL
Hepatomegaly	☐ Yes	☐ No	HBV DNA	/ /	_____	IU/mL
Splenomegaly	☐ Yes	☐ No	AST (SGOT)	/ /	_____	IU/L
Pruritus	☐ Yes	☐ No	ALT (SGPT)	/ /	_____	IU/L
Fatigue	☐ Yes	☐ No	Total Bilirubin	/ /	_____	mg/dL
Spider Angiomata	☐ Yes	☐ No	Albumin	/ /	_____	g/dL
Palmar Erythema	☐ Yes	☐ No	Platelet Count	/ /	_____	10^9/L
Other: *(specify)* _____			PT INR	/ /	_____	sec

Non-invasive tests for detection of cirrhosis *(use the most recent lab results)*	**Date done**	**Result**	
Aminotransferase/Platelet Ratio Index Score	____ / ____ / _____	☐ ≤ 2	☐ > 2
Fibrosis 4 / FIB-4 Score	____ / ____ / _____	☐ ≤ 3.25	☐ > 3.25
Transient Elastography	____ / ____ / _____	☐ < 12.5 kPa	☐ ≥ 12.5 kPa
Imaging (UTZ/CT/MRI)	____ / ____ / _____	☐ Cirrhosis ☐ Mass	☐ No cirrhosis ☐ No mass
Child-Turcotte-Pugh Class Score	____ / ____ / _____	☐ Class A	☐ Class B ☐ Class C

Did the client **develop liver cirrhosis** following treatment? ☐ Yes ☐ No

Did the client **develop hepatocellular carcinoma** following treatment? ☐ Yes ☐ No

Did the client acquire/develop any of the following compared from the last visit:

☐ Hepatitis B co-infection (if the client was initially diagnosed with Hepatitis C infection) ☐ HIV co-infection

☐ Hepatitis C co-infection (if the client was initially diagnosed with Hepatitis B infection) ☐ Other: _____

IV. TREATMENT

Is the client **eligible for treatment?**

☐ Yes, the client is eligible for treatment for Hepatitis B ☐ No, the client is not eligible for treatment and was advised to return for monitoring on: *(mm/dd/yyyy)*____ / ____ / _____ ☐ Awaiting for laboratory results

☐ Yes, the client is eligible for treatment for Hepatitis C

Treatment status:

☐ Enrolling this visit ☐ Continuing/refill ☐ Returning client ☐ Not on treatment (*reason if not on treatment:* _____)

Regimen:	**Date dispensed** *(mm/dd/yyyy)*	**# pills missed** *(past 30 days)*	**# of pills on hand**	**# of pills dispensed**	**Expected date of refill** *(mm/dd/yyyy)*
☐ Sofosbuvir (400 mg) ☐ Tenofovir(TDF) (300 mg) ☐ Daclatasvir (60 mg)	____ / ____ / _____	_____	_____	_____	____ / ____ / _____
☐ Sofosbuvir/Velpatasvir ☐ Ribavirin	____ / ____ / _____	_____	_____	_____	____ / ____ / _____
☐ Other: _____					

If the patient's treatment was <u>discontinued</u> , please completely fill out this section.

Date discontinued: ____ / ____ / _____ **Reason:** *(D/C code)*_____ *(For code 6 & 7, please specify)* _____

Discontinuation codes (D/C):
1-Treatment Failure 2-Clinical progression 3-Patient Decision/Request 4-Compliance difficulties 5-Drug Interaction 6-Adverse Event (Specify) 7-Others (Specify) 8-Cured(for Hepatitis C) 9-Death

Please send this accomplished form to Epidemiology Bureau - Department of Health , 2/F Rm. 212, Building 19, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila. Contact No: +63 2 8651-7800 loc. 2952

Note: Creating UIC - First two letters of mother's name + First two letters of father's name + Birth order + Date of birth (mm-dd-yyyy)