

Perinatal Hepatitis C Fax Form

Send by **confidential fax (253) 649-1389** or call **24-hour reporting line (253) 649-1413**.

A Fill out this section to notify the Health Department of a **pregnant woman with positive hepatitis C (HCV) results**.

Patient
Name (last, first)
Address
City, State Zip
Phone
Date of Birth (m/d/yy)
Race (check all that apply) ☐ Am. Indian/AK Native ☐ Asian ☐ Black ☐ Native HI/Other PI ☐ White ☐ Unknown
Hispanic ☐ Yes ☐ No ☐ Unknown
Estimated Date of Delivery (m/d/yy)

Reporter
Today's Date (m/d/yy)
Name
Provider
Agency
Phone
Was patient notified of positive HCV? ☐ Yes ☐ No
Does patient have a history of HCV? ☐ Yes ☐ No ☐ Unknown
Does patient have other children? ☐ Yes ☐ No

Lab Results—Fax labs along with this form.

HCV Antibody Results

☐ Negative ☐ Positive—Requires RNA test.

HCV RNA Results

☐ Negative ☐ Positive

B Fill out this section after the **birth of exposed infant** or ☐ **This pregnancy did not result in a live birth.**

Infant
Name (last, first)
Date of Birth (m/d/yy)
Address or ☐ Same as above
Was patient notified of the need to test infant for HCV? ☐ Yes ☐ No
Where was mother referred for HCV treatment?

Pediatric Healthcare Provider
Today's Date (m/d/yy)
Pediatrician Name
Phone
Was pediatrician notified of infant's exposure to HCV? ☐ Yes ☐ No