KHAMP HEP C: KNOW MORE
Kentucky Hepatitis Academic Mentorship Program

CONSULTATION FORM

Please send to secure fax: 833-496-6214

KHAMP Scholar/Provider Name:	**Fax:** **Phone:**	**NPI:**

PATIENT INFORMATION

Patient Last Name:	**Patient First Name:**	**Patient M.I.:**	**Patient Zip Code:**

Date of Birth: / /	**Sex:** ☐ Male ☐ Female ☐Transgender	**Height:**	**Weight:**

Current Medications:

Medical History:	**Payer Source:** ☐Medicaid ☐Medicare ☐Private Ins ☐Uninsured	**If Female, Pregnant:** ☐ Yes ☐ No ☐ Unknown **Postpartum (≤6 weeks):** ☐ Yes ☐ No ☐ Unknown
Est. Delivery Date:	**Perinatally acquired:**☐Yes☐No☐Unknown	

Substance Use Disorder: ☐ Yes ☐ No ☐ Unknown	**Behavioral Health Referral:** ☐ Yes ☐ No ☐ Unknown	**If Referred, to whom:**

LABORATORY INFORMATION

Date of Test	Type of Test	Results	RNA Results	
	☐ HCV Antibody ☐ HCV RNA	☐ + ☐ -	Quantitative Result:	Genotype:

CBC:	**CMP:**	**PT/INR:**

HBV: ☐ Immunity ☐ Vaccinated	**HAV:** ☐ Immunity ☐ Vaccinated	**HIV:** ☐ + ☐ - *(refer HIV/HCV + to specialist)*

Encephalopathy: ☐ Yes ☐ No	**Ascites:** ☐ Yes ☐ No	**Hx of GI Bleed:** ☐ Yes ☐ No	**Advanced Cirrhosis:** ☐ Yes ☐ No

FIBROSIS ASSESSMENT

☐ **FibroScan** ☐ **FibroSure**	**Results:** *(refer fibrosis score of 3 or greater to specialist)*

Cirrhosis Status: ☐ No Cirrhosis ☐ Compensated Cirrhosis(Child-Pugh A/B) ☐ Decompensated Cirrhosis(Child-Pugh C)

TREATMENT

Date Started: / /	**Treatment Status:** ☐ Naïve ☐ Experienced	**Medication Prescribed:**	**Duration:** ☐ 8 weeks ☐ 12 weeks

Date Completed: / /	**If treatment not completed, why?** ☐ Lost to follow-up ☐ Incarcerated ☐ Deceased ☐ Other (explain) :

Persistent Infection:

KHAMP FACULTY CONSULTATION

KHAMP Faculty/ Consultant Name:		**NPI:**
Date Consulted: / /	**Facility:**	**Specialty:** ☐ Gastroenterology ☐ Hepatology ☐ Infectious Disease

REFERRAL TO SPECIALISTS FOR EVALUATION

Provider:	**Date Referred:** / /

Notes:

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The patient understands that:

Protected health information will be disclosed and used for hepatitis C consultation, treatment, and follow up. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of consultation, treatment, and follow up upon the execution of this Consent.

This consent was signed by:

_____
Printed Name-Patient or Responsible Party

_____
Patient Signature or Responsible Party Date

_____
Relationship to patient (if other than patient)

Witness: _____

Printed Name-Practice Representative
_____
_____/_____/_____
Signature Date

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