Hep C Navigation Form - Peer Outreach

Organization:	Peer Navigator:		Supervisor:	
Client Information		**Self-Reported History**	**Hep C Tests**	**Hep C Medical Visit**
Name: **Tel:** **Email:** **Name insurance plan:** ☐Medicaid ☐Medicare ☐Private ☐None **Participant ID#:** ________________ **Date enrolled in Hep C Peer Nav:** ____/____/______ **Required:** ☐Health coaching ☐Harm Reduction Services	**Date of Birth:** __________ **Gender:** ☐F ☐M ☐Trans M→F ☐Trans F→M ☐Other **Race:** ☐White ☐Black or African American ☐Asian/PI ☐Native American /Alaskan Native ☐Native Hawaiian ☐Other race:__________ ☐Does not identify ☐Decline to answer ☐Unknown **Ethnicity:** ☐Hispanic/Latino: Specify________ ☐Non-Hispanic/Non-Latino: Specify ________ ☐Decline to Answer ☐Unknown **English:** ☐Speak ☐Read ☐Write ☐None **Primary language:** _______________ **Interpretation needed:** ☐Yes ☐No	**Self-reported Hep C Status:** + - ? **Treated Hep C before?** ☐Yes ☐No **If treated, outcome:** ☐Cured ☐Not cured **Re-infected?** ☐Yes ☐No ☐Unknown	**Antibody Test date:** ____/____/_______ ☐ Declined ☐ Not Needed **Hep C Antibody Test Result:** + - **RNATest date:** ____/____/_______ ☐ Declined ☐ Not Needed **Hep C RNA Test Result:** + -	**Hep C medical care referral provided:** ☐Yes ☐No ☐Already in Care **Referral Status:** ☐Accepted ☐Declined **Provider Name:** **Provider Clinic:** **Hep C medical visit attended** date: ____/____/_______ **Hep C treatment:** ☐Started ☐Completed ☐Discontinued **Hep C treatment outcome:** ☐Cured ☐Not Cured
Name: **Tel:** **Email:** **Name insurance plan:** ☐Medicaid ☐Medicare ☐Private ☐None **Participant ID#:** ________________ **Date enrolled in Hep C Peer Nav:** ____/____/______ **Required:** ☐Health coaching ☐Harm Reduction Services	**Date of Birth:** __________ **Gender:** ☐F ☐M ☐Trans M→F ☐Trans F→M ☐Other **Race:** ☐White ☐Black or African American ☐Asian/PI ☐Native American /Alaskan Native ☐Native Hawaiian ☐Other race:__________ ☐Does not identify ☐Decline to answer ☐Unknown **Ethnicity:** ☐Hispanic/Latino: Specify________ ☐Non-Hispanic/Non-Latino: Specify ________ ☐Decline to Answer ☐Unknown **English:** ☐Speak ☐Read ☐Write ☐None **Primary language:** _______________ **Interpretation needed:** ☐Yes ☐No	**Self-reported Hep C Status:** + - ? **Treated Hep C before?** ☐Yes ☐No **If treated, outcome:** ☐Cured ☐Not cured **Re-infected?** ☐Yes ☐No ☐Unknown	**Antibody Test date:** ____/____/_______ ☐ Declined ☐ Not Needed **Hep C Antibody Test Result:** + - **RNATest date:** ____/____/_______ ☐ Declined ☐ Not Needed **Hep C RNA Test Result:** + -	**Hep C medical care referral provided:** ☐Yes ☐No ☐Already in Care **Referral Status:** ☐Accepted ☐Declined **Provider Name:** **Provider Clinic:** **Hep C medical visit attended** date: ____/____/_______ **Hep C treatment:** ☐Started ☐Completed ☐Discontinued **Hep C treatment outcome:** ☐Cured ☐Not Cured