Hep C Navigation Form - Community Settings

Navigator
Supervisor

Client Information

Date enrolled:	Agency Participant ID:	Initials:	Year of Birth:
Client First Name:	Client Last Name:		Date of Birth:
Address (# street, apt #, borough) Zip code		Phone 1:	Phone 2:
Race: ☐ White ☐ Asian/PI ☐ Native Hawaiian ☐ Does not identify ☐ Decline to answer ☐ Unknown	☐ Black or African American ☐ Native American /Alaskan Native ☐ Other race:_____	Ethnicity: ☐ Hispanic/Latino Specify_____ ☐ Non-Hispanic/Non-Latino Specify _____ ☐ Decline to Answer ☐ Unknown	Gender: ☐ F ☐ Trans M→ F ☐ M ☐ Trans F→ M ☐ Other
English: ☐ Speak ☐ Read ☐ Write ☐ None		Preferred language:	Interpretation needed: ☐ Yes ☐ No

For organization use only

Email: _____ **Emergency Contact Phone:** _____

Other Contact Info:

Program Services

***Required services at time of enrollment:**	☐ Health Coaching	☐ Harm Reduction
***Services:**	☐ Enrolled in Hep C Peer Services	☐ Enrolled in full-time Hep C patient navigation

Hep C Testing On or After Enrollment

Hep C status at intake: ☐ Positive ☐ Negative ☐ Unknown	
Antibody test date: ___/___/_____ ☐ Test declined ☐ Test not needed	Antibody test result: ☐ Positive ☐ Negative
RNA test date: ___/___/_____ ☐ Test declined ☐ Test not needed	RNA test result: ☐ Positive ☐ Negative ☐ Spontaneously cleared virus

Assessment

Treated for Hep C before program? ☐ Yes, year:____ ☐ No	If ever treated, cured? ☐ Cured ☐ Not cured
Insurance: ☐ Medicaid ☐ Medicare ☐ Private ☐ None	Name of insurance plan:
In the past year, have you had trouble paying for food, housing, medications, heating or other basic need? ☐ Yes ☐ No	
Housing: ☐ Stable housing ☐ Unstable housing ☐ Homeless	Has consistent transportation for appointments: ☐ Yes ☐ No
Injected drugs in the past year? ☐ Yes ☐ No ☐ Declined Inhaled/snorted drugs in the past year? ☐ Yes ☐ No ☐ Declined Ever injected drugs? ☐ Yes ☐ No ☐ Declined	On methadone: ☐ Yes ☐ No On buprenorphine: ☐ Yes ☐ No
Alcohol use in the past year? ☐ Yes ☐ No ☐ Declined Any mental health issues? ☐ Yes ☐ No ☐ Unknown Social support? ☐ None ☐ Family ☐ Friends ☐ Support group ☐ Program	Incarcerated in past year: ☐ Yes ☐ No ☐ Declined Incarcerated ever: ☐ Yes ☐ No ☐ Declined

Navigation to Supportive Services

☐ Alcohol Treatment	☐ Hep C Genotype and Resistance Testing	☐ Mental Health Services
☐ Benefits Enrollment	☐ Hep C Support Groups	☐ Primary Care
☐ Hep A Vaccination	☐ HIV Care	☐ Substance Use Services
☐ Hep B Care	☐ HIV Testing	☐ Transportation Services
☐ Hep B Testing	☐ Holistic Services	☐ Other:
☐ Hep B Vaccination	☐ Housing Services	

☐ **Health Promotion "Hep C Basics" complete**
☐ **Health Promotion "Getting Ready for Hep C Care" complete**
☐ **Care Plan developed and reviewed with patient**

Hep C Medical Care After Enrollment

Hep C medical care referral provided:
☐ Yes ☐ No ☐ Already in Care
Hep C medical visit attended date: ___/___/_____
Date must be on or after enrollment

Provider name:
Provider hospital/clinic:

Co-morbid conditions: ☐ HIV ☐ Hep B
Hep C treatment status: ☐ Started ☐ Completed ☐ Discontinued
Hep C treatment outcome: ☐ Cured ☐ Not Cured ☐ Unknown

Adherence check-in frequency during treatment:
☐ Weekly ☐ Other:

Barriers to Hep C Treatment:

☐ Abstinence requirement	☐ Drug use	☐ Recently incarcerated
☐ Alcohol use	☐ Homeless/Unstable housing	☐ Waiting for new medications
☐ Client declined treatment	☐ Insurance coverage/ cost	☐ Other:
☐ Co-morbid conditions	☐ Lost to follow up	
☐ Did not attend appointments	☐ Psych condition	

Reinfection prevention support provided after treatment:
☐ 1 month ☐ 3 months ☐ 6 months ☐ Referred to group that covers Hep C reinfection prevention

☐ **Health Promotion "Getting Ready for Hep C Treatment" complete**
☐ **Treatment Planning Form reviewed with patient**
☐ **Health Promotion "After Treatment" complete**

Discharge date: ___/___/_____
Total # encounters with client:

Reason: ☐ Completed program ☐ Deceased ☐ Declined program ☐ Incarcerated
☐ Lost to follow up ☐ Moved ☐ Program ended ☐ Referred to another program
☐ Other, explain:

Notes