

**MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA**

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	DTSG APPROVED (Date) (YYYYMMDD)
--------------	------------------------------------

**Hepatitis C Screening**

The following statements will be overprinted on a DA Form 4700 and enclosed in the (Medical Record-Supplemental Medical Data), and placed in the medical records of all soldiers separating or retiring from active duty. Soldiers will be instructed to read the statement and indicate in the space whether or not they want to be screened for Hepatitis C infection.

1. Hepatitis C is transmitted primarily by contaminated blood (e.g. blood transfusions, contaminated needles, or sticks with contaminated sharp objects). The following are possible sources of Hepatitis C infection (HCV). If you can answer "yes" to any of these risk factors, you should receive a sample blood test to determine if you could have Hepatitis C. If you consider yourself at risk, based on an exposure to a possible source of Hepatitis C virus, you should have a simple blood test for HCV. You will not be asked to identify any specific risk factors to justify HCV testing. If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on life-style modifications and steps to protect others from infection.

**2. Risk Factors**

- a. Receiving a transfusion of blood or blood products before 1992.
- b. Ever injecting illegal drugs, including use once many years ago.
- c. Receiving clotting factors concentrates produced before 1987.
- d. Having chronic (long term) hem dialysis.
- e. Being told that you have persistent abnormal liver enzyme tests (alanine aminotransferase) or an unexplained liver disease.
- f. Receiving an organ transplant before July 1992.
- g. Having a needle stick, sharps or mucosal exposure to potentially HCV-infected blood as part of your occupational duties and not been previously evaluated for HCV infection.

3. If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on life-style modifications and steps to protect other from infection.

4. Circle yes or no to one of the following responses and sign and date.

- a. No- I do not want to be tested for hepatitis C.
- b. Yes- I want to be tested for hepatitis C.

c. Signature \_\_\_\_\_ Date \_\_\_\_\_

*(Continue on reverse)*

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
---------------------------------	---------------------------	-----------------

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle, grade, date, hospital or medical facility)  NAME _____  SSN _____	<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify)  <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT
------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------