The national register contains information on HCV infections with known dates of acquisition/exposure, and provides a facility for the future monitoring and long term assessment of HCV infection within the UK.

No patient names are held in the HCV National Register. It is therefore very important that you retain the register number in your records and that you are able to trace the patient from either the register number or the identifier/reference number that you supply on the form (Question 1).

Ethical approval for the register has been obtained from the North Thames Multi-Centre Research Ethics Committee.

Enquiries regarding either the HCV National Register or completion of the form should be directed to:

Dr Helen Harris (Register Co-ordinator)
Telephone: 020 8327 7676
Email: helen.harris@phe.gov.uk

Ms Annastella Costella (Hepatitis Scientist)
Telephone: 020 8327 7086
Email: annastella.costella@phe.gov.uk

The HCV National Register is operated by Public Health England.
Section 1: PATIENT DETAILS (please insert details or tick boxes as appropriate)

1. Identifier by which you can recognise the patient in current and future correspondence (eg. hospital number):

Patient NHS number: ____________________________

2. Are you still responsible for the HCV-related care of the patient?

Yes ☐ ☐ Please continue

No ☐ ☐ Please go straight to Section 6

3. Has this patient been seen, treated, or tested for HCV-related illness since their last report (see front of form for date of last report)?

Yes ☐ ☐ Please complete the rest of the form

No ☐ ☐ Please go to question 3

Section 2: CURRENT CLINICAL STATUS

The next questions ask about the patient’s current clinical status. In this context, clinical status is intended to reflect the patient’s signs and/or symptoms of liver disease, not their test results.

1. Has the patient died (please tick box)?

Yes ☐ ☐ No ☐ ☐

If yes, please give date of death (dd/mm/yyyy) ____________________________ and cause of death: ____________________________

If no, does the patient have: No clinical signs or symptoms of liver disease ☐ ☐

Clinical signs or symptoms of liver disease (HCV-related) ☐ ☐

Clinical signs or symptoms of liver disease (not HCV-related) ☐ ☐

Please go to question 3

2. Please record any signs or symptoms of liver disease:

Spider naevi ☐ ☐

Hepatomegaly ☐ ☐

Splenomegaly ☐ ☐

Ascites ☐ ☐

Varices ☐ ☐

Bleeding varices ☐ ☐

Liver tumour ☐ ☐

Palmar erythema/Liver palms ☐ ☐

Encephalopathy ☐ ☐

Jaundice ☐ ☐

Other (please give details): ____________________________

3. Does the patient suffer from any other significant medical conditions (please tick box)?

Yes ☐ ☐ No ☐ ☐

If yes, please specify: ____________________________

4. Is the patient obese (BMI ≥30)?

Yes ☐ ☐ No ☐ ☐

Section 3: TEST RESULTS SINCE LAST REPORT (see front of form for date of last report)

1. Date of last consultation for HCV since last report (dd/mm/yyyy): ____________________________

2. Date of latest HCV PCR test results since last report (dd/mm/yyyy): ____________________________

Results (please tick box): Positive ☐ ☐ Negative ☐ ☐ Not known ☐ ☐ Other (eg. viral load): ____________________________

3. Date of latest HCV antibody test results since last report (dd/mm/yyyy): ____________________________

Results (please tick box): Positive ☐ ☐ Negative ☐ ☐ Equivocal ☐ ☐ Not known ☐ ☐

4. Please insert the HCV genotype or serotype if known: ____________________________

5. Date of latest liver function tests since last report (dd/mm/yyyy):

Please give results and test ranges: AST ☐ ☐ Abnormal ☐ ☐ Normal ☐ ☐

Albumin ☐ ☐ Abnormal ☐ ☐ Normal ☐ ☐

INR/PTT ☐ ☐ Abnormal ☐ ☐ Normal ☐ ☐

Bilirubin ☐ ☐ Abnormal ☐ ☐ Normal ☐ ☐

6. Date of latest haematology tests since last report (dd/mm/yyyy):

Please give results and test ranges: Platelets ☐ ☐ Abnormal ☐ ☐ Normal ☐ ☐

7. Date of latest liver biopsy since last report (dd/mm/yyyy):

8. Date of latest Fibroscan (dd/mm/yyyy):

a. Date of previous Fibroscan (dd/mm/yyyy): ____________________________

b. Date of previous Fibroscan (dd/mm/yyyy): ____________________________

Section 4: ANTIVIRAL DRUG TREATMENT SINCE LAST REPORT (see front of form for date of last report)

1. Has the patient had any antiviral treatment for HCV since the date of the last report?

Yes ☐ ☐ No ☐ ☐

If yes, please insert details of treatment in the table below:

<table>
<thead>
<tr>
<th>COURSE</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date started (dd/mm/yyyy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date finished (dd/mm/yyyy)</td>
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<tr>
<td>Interferon preparation (e.g. pegylated)</td>
<td></td>
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<tr>
<td>Interferon dosage (mU)</td>
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<tr>
<td>Interferon schedule (e.g. Daily, twice weekly)</td>
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<tr>
<td>Ribavarin dosage (please give units)</td>
<td></td>
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</tbody>
</table>

2. What was the response to the latest course of treatment? (please tick only one of the 8 boxes below)

Transient response (PCR negative during treatment but became positive after treatment completed)

Immediate/initial response (PCR negative <6/12 months after treatment completed)

Sustained response (remains PCR negative 6/12 months after treatment completed)

Long term response (remains PCR negative 12/12 months after treatment completed)

Late relapse (PCR negative >12/12 months after treatment completed)

No response (never became PCR negative)

Treatment stopped early (e.g. due to side effects)

Not relevant (still on treatment)

Not known

If yes, please specify: ____________________________

If yes, please go to question 3

3. Has the patient taken part in any antiviral drug trials since the date of the last report?

Yes ☐ ☐ No ☐ ☐

If yes, please give details: ____________________________

Patient registration/code number: ____________________________ Date of entry: ____________________________

4. Has the patient received any other treatment for HCV since the date of the last report (e.g. herbal treatments)?

Yes ☐ ☐ No ☐ ☐

If yes, please give details: ____________________________

THANK YOU VERY MUCH FOR YOUR HELP.