Section 5: CURRENT MANAGEMENT SINCE LAST REPORT *(see front of form for date of last report)*

1. What care has the patient received for HCV-related illness since the date of the last report?

None ☐ Outpatient only ☐ Inpatient (assessment only, eg. liver biopsy) ☐ Inpatient (medical care) ☐

If the patient has received ***any inpatient care*** **for HCV-related illness** since the last report, please supply the following information for each admission:

Care episode	Date of admission (dd/mm/yy)	Date of discharge (dd/mm/yy)	Ward type, eg. General Medical, ICU, Liver Unit, HDU etc	Reason for admission	
				Tick if liver biopsy	Other (please state)
1				☐	
2				☐	
3				☐	
4				☐	

2. If the patient has had any outpatient care for HCV since the date of the last report, how many outpatient appointments have they had?

Please state the number of appointments: _____

3. Has the patient had a liver Ultrasound Scan (US) since the date of the last report? Yes ☐ No ☐

4. Has the patient undergone any other procedures (like therapeutic banding gastroscopy, TIPPS, alcoholic injection of the liver, laser ablation of the liver, etc.) for their HCV-related liver disease? Yes ☐ No ☐

If **yes**, please specify the procedures and the number of times each procedure has been undergone: _____

_____

_____

_____

5. What is the patient's current alcohol intake (in units of alcohol/week, if possible)? _____ Not known ☐

Section 6: COMMENTS

If you have any comments that you would like to make, please do so in the space below:

Please print your details below so that we can contact you if we need more information about this patient:

Your name: _____

Date (dd/mm/yyyy): ____/____/_____ Telephone number: _____

Email address: _____

THANK YOU VERY MUCH FOR YOUR HELP
ALL THE INFORMATION YOU PROVIDE WILL BE TREATED IN CONFIDENCE

PLEASE RETURN THIS FORM USING REPLY PAID ENVELOPE TO:

Annastella Costella, Immunisation, Hepatitis and Blood Safety Department, Health Protection, Public Health England, 61 Colindale Avenue, London, NW9 5EQ

The HCV National Register is operated by Public Health England

V May 14

NATIONAL REGISTER HCV

NATIONAL REGISTER OF HCV INFECTIONS WITH A KNOWN DATE OF ACQUISITION

FOLLOW-UP FORM

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

DATE OF LAST REPORT: ____/____/_____

Register number: _____

Date of birth: ____/____/_____

Soundex/initials: _____

Your reference: _____

NHS No: _____

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 give the name and address of the clinician now responsible for the HCV-related care of this patient (and then return the form to us). Please also ensure that you insert your details at the end of this form so that we can contact you if we need more information about this patient.*
THANK YOU VERY MUCH FOR YOUR HELP.

Name: _____

Address: _____

_____

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

Yes ⇨ *Please complete the rest of the form*

No ⇨ *Please go straight to Section 6*

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, *<u>not</u>* 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 ⇨ ***Please go to question 3***

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

Clinical signs or symptoms of liver disease (not HCV-related) ⇨ Details/cause: _____

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 <u>SINCE</u> LAST REPORT *(see front of form for date of last report)*

1. Date of last consultation for HCV <u>since</u> last report (dd/mm/yyyy): ____/____/_____

2. Date of latest HCV PCR test results <u>since</u> last report (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐

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

3. Date of latest HCV antibody test results <u>since</u> last report (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐

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

4. Please insert the HCV genotype or serotype if known: _____ Not known ☐

5. Date of latest liver function tests <u>since</u> last report (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐

Results (please tick box or enclose copy of report form): Normal ☐ Abnormal ☐ Not known ☐

Please give results and test ranges: ALT _____ Range _____ AST _____ Range _____

Bilirubin _____ Range _____ Albumin _____ Range _____

6. Date of latest haematology tests <u>since</u> last report (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐

Please give results and test ranges: INR/PTT _____ Range _____ Platelets _____ Range _____

7. Date of latest liver biopsy <u>since</u> last report (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐

Results (please tick box): Normal ☐ Abnormal ☐ Not known ☐

If **abnormal**, please give results (enclose copy of report form, if possible):

Minimal change ☐ Chronic hepatitis ☐ Cirrhosis ☐ Hepatocellular carcinoma ☐

Fibrosis score (if known): _____ Scoring system: _____

Histopathology department biopsy reference number: _____

8. Date of latest Fibroscan (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐ Fibroscan score: _____ kPa (range ____ - _____)

a. Date of previous Fibroscan (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐ Fibroscan score: _____ kPa (range ____ - _____)

b. Date of previous Fibroscan (dd/mm/yyyy): ____/____/_____ Not done ☐ Not known ☐ Fibroscan score: _____ kPa (range ____ - _____)

Section 4: ANTIVIRAL DRUG TREATMENT <u>SINCE</u> LAST REPORT *(see front of form for date of last report)*

1. Has the patient had any antiviral treatment for HCV <u>since</u> the date of the last report? **Yes** ⇩ *Please continue with this section* **No** ⇩ *Please go to question 3*

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

COURSE	A	B	C
Date started *(dd/mm/yy)*			
Date finished *(dd/mm/yy)*			
Interferon preparation *(state if pegylated)*			
Interferon dosage *(mU)*			
Interferon schedule *(e.g. Daily, twice weekly)*			
Ribavarin dosage *(please give units)*			
Ribavarin Schedule *(e.g. Daily, twice weekly)*			
Telaprevir. If yes, date started *(dd/mm/yy)*			
Boceprevir. If yes, date started *(dd/mm/yy)*			
Other antivirals. *Please give name.*			
Other antivirals dosage *(please give units)*			
Other antivirals Schedule *(e.g. Daily, twice weekly)*			

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

☐ Not relevant (still on treatment)
☐ Treatment stopped early (eg. due to side effects)
☐ No response (never became PCR negative)
Response:
☐ Late relapse (PCR negative >12/12 after treatment but became positive at a later date)
☐ Long term response (remains PCR negative 12/12 after treatment completed)
☐ Sustained response (remains PCR negative 6/12 after treatment completed)
☐ Immediate/initial response (PCR negative <6/12 after treatment completed)
☐ Transient response (PCR negative during treatment but became positive after treatment)

3. Has the patient taken part in any antiviral drug trials <u>since</u> the date of the last report? Yes ☐ No ☐

If **yes**, please give details: Name of trial: _____

Patient registration/code number: _____ Date of entry: ____/____/_____

4. Has the patient received any other treatment for HCV <u>since</u> the date of the last report (eg. herbal treatments)? Yes ☐ No ☐

If **yes**, please give details: _____