



## BC Enhanced Hepatitis Strain Surveillance Project Hepatitis C

### Informed Consent: Please read to individual and answer any questions

There are about 60,000 people with hepatitis C in BC. We want to find out exactly how people here are getting infected, and we hope we can prevent some of these infections in the future. To do this, we want to talk to people who, like you, have hepatitis C. With your permission, I'd like to ask you a few questions about yourself and about some of the ways you might have become infected. **Any information you give us will be kept completely private.** It will not affect your medical care if you don't want to participate, or if you decide that you want to stop answering questions at any point.

Do you have any questions about this study? Are you willing to help us by completing the questionnaire, it should just take about 20 minutes?

**If no**, "Thank you very much anyway for your time. Have a good day."

**If yes**, "Thank you very much. This should only take about 20 minutes."

### Acute HCV Questionnaire

Consent to study:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Infection:</b>	<input type="checkbox"/> Acute HCV <input type="checkbox"/> Acute HBV <input type="checkbox"/> Acute HCV & HBV Co-infection	
Enhanced Surveillance interview done?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, why not?	<input type="checkbox"/> Refused	<input type="checkbox"/> Unable to locate <input type="checkbox"/> Died <input type="checkbox"/> Non-case
	<input type="checkbox"/> Language Barrier	<input type="checkbox"/> Other
Interviewer name and signature:	_____	
Interview date (dd/mm/yyyy)	_____	

### 1. Demographics: "First, I'd just like to get some basic information from you."

Name:	_____
Address:	_____
Telephone number:	_____
Personal Health Number:	_____
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (yyyy/mm/dd):	_____
Parent/Guardian name (if applicable):	_____
Where were you born?	<input type="checkbox"/> Canada <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
<b>(If born outside Canada)</b> What year did you come to Canada?	_____
To what ethnic or cultural group do you belong?	<input type="checkbox"/> Caucasian <input type="checkbox"/> Indian (S. Asian) <input type="checkbox"/> Aboriginal – First Nations <input type="checkbox"/> Aboriginal – Metis <input type="checkbox"/> Aboriginal – Inuit <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Unknown <input type="checkbox"/> Declined <input type="checkbox"/> Other: _____

## 2. Clinical Information

Physician name & city: \_\_\_\_\_

Laboratory name: \_\_\_\_\_

Specimen number: \_\_\_\_\_

### Lab Results (fill in available results and/or attach relevant lab reports)

Date (yyyy/mm/dd): \_\_\_\_\_

Anti-HAV IgM	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HAV Total	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
HBsAg	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HBc IgM	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HBc	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HBs	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
HBe Ag	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HCV	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
HCV RNA	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate

Previous results: Date (yyyy/mm/dd): \_\_\_\_\_

HBsAg	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HBs	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HBc	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Anti-HCV	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate

### Why was the patient tested for HBV and/or HCV? (More than one response is possible)

Routine  
  Prenatal  
  Symptomatic  
  Risk factors  
  Elevated liver enzymes  
 Insurance and/or blood donation testing  
 Don't know  
 Refused to answer  
 Other, specify \_\_\_\_\_

### “Do you know if your liver enzymes (AST or ALT) have ever been high?”

Yes  
  No  
  Test not done  
  Unknown

Value (ALT): \_\_\_\_\_ Value (AST): \_\_\_\_\_

Date (yyyy/mm/dd): \_\_\_\_\_ Date (yyyy/mm/dd): \_\_\_\_\_

### Symptoms: “Have you experienced any of the following symptoms in the past 6 months?”

Dark Urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Malaise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Loss of Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Date of Onset of First Symptom(s) (yyyy/mm/dd): \_\_\_\_\_

#### 4. Blood Donation

<b>“Have you ever donated blood?”</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Declined
When? _____	Where? _____		
When? _____	Where? _____		
When? _____	Where? _____		

#### 5. HIV Testing

Has the patient ever been tested for HIV? (HIV testing done with a blood sample)
<input type="checkbox"/> Yes , When was the patient’s last HIV test? _____
<input type="checkbox"/> No
<input type="checkbox"/> Refused to answer
<input type="checkbox"/> Unknown
If yes, what was the result of the patient’s last HIV test
<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Results Pending <input type="checkbox"/> Refused to answer

#### 6. Socio-Economic Status

What is the patient’s current marital status?
<input type="checkbox"/> Single <input type="checkbox"/> Married
<input type="checkbox"/> Common-Law <input type="checkbox"/> Separated/Divorced <input type="checkbox"/> Widowed
What is the patient’s current employment status?
<input type="checkbox"/> Employed <input type="checkbox"/> Self-employed, Occupation _____
<input type="checkbox"/> Unemployed <input type="checkbox"/> Social assistance or EI <input type="checkbox"/> Refused to answer
What is the patient’s occupation? _____
What is the patient’s highest level of completed education?
<input type="checkbox"/> None <input type="checkbox"/> Elementary <input type="checkbox"/> Secondary
<input type="checkbox"/> Technical/Trade <input type="checkbox"/> College/University <input type="checkbox"/> Refused to Answer
<input type="checkbox"/> Don’t know <input type="checkbox"/> Other
How many times has the patient moved in the past 12 months? Number of times _____
Has the patient lived in any of the following in the last 12 months – check all that apply.
<input type="checkbox"/> My apartment/house <input type="checkbox"/> Friend/relative’s house <input type="checkbox"/> Hotel/motel/rooming house
<input type="checkbox"/> Shelter/hostel <input type="checkbox"/> Halfway house/detox/rehab <input type="checkbox"/> street
<input type="checkbox"/> Squat <input type="checkbox"/> Corrections <input type="checkbox"/> Psychiatric facility
<input type="checkbox"/> Refused <input type="checkbox"/> Don’t know <input type="checkbox"/> Other _____

#### 7. Epidemiologic Data

**“The next group of questions is about ways that people get infected with hepatitis C.”**

Was there anyone in your household who had hepatitis C or was an injection drug user (IDU)?

- Yes  No  Unknown  Declined
- If yes, were they**  HCV positive  IDU  HCV pos. & IDU  Unknown

**If yes, what was their relationship to you?**

- Spouse/partner    Mother    Father    Sibling  
 Child    Grandparent    Unknown    Other \_\_\_\_\_

**(For minors)** Was the patient born to a hepatitis C infected mother?

- Yes    No    Unknown    Declined

**If yes**, has confirmatory testing been performed on the infant?

- Yes    No    Unknown    Declined

**If yes**, test result? \_\_\_\_\_ Test Date \_\_\_\_\_

**Please check/complete all fields that apply:**

	Potential Exposure	Yes, in last 12 mos	Yes, Ever	Check if Outside of Canada	No	Declined
1.	Have you had an organ or tissue transplant? If yes, what was it (e.g., organ, bone, bone marrow, assisted reproduction)? _____.					
2.	Have you ever had a blood transfusion?					
3.	Have you ever received blood products (e.g., clotting factors, immune globulin, albumin)?					
4.	Have ever had surgery?					
5.	Have you ever had dental surgery?					
6.	Have you ever had hemodialysis <sup>1</sup> ?					
7.	Have you ever had an endoscopy <sup>2</sup> ? _____.					
8.	Have you ever had acupuncture?					
9.	Have you had other medical procedures (e.g., EEG)? If yes, what procedure _____.					
10.	Have you ever had any part of your body pierced?					
11.	Have you ever been tattooed?					
12.	Have you injected non-prescription drugs? If yes, for how long did you inject/have you been injecting?					
	Did you ever share needles, syringes or other materials (e.g. cooker, cotton) with others?					
	If yes, with how many people in last 12 months & > 12 months?					
13.	Have you had other exposure to needles (e.g., electrolysis)?					
14.	Have you used non-injection drugs?					
	Did you ever share straws or other snorting equipment?					

<sup>1</sup> Dialysis is a method of removing impurities or wastes from the blood when the kidneys are unable to do so.

<sup>2</sup> Endoscopy is when a small tube with a camera is inserted to look for abnormalities.

	Potential Exposure	Yes, in last 12 mos	Yes, Ever	Check if Outside of Canada	No	Declined
	If yes, with how many people in last 12 months & > 12 months?					
	Did you ever share crack pipes or other smoking equipment?					
	If yes, with how many people in last 12 months & > 12 months?					
15.	Have you had sex with someone of the opposite sex? If yes, how many partners have you had in the last 12 months and before the last 12 months?					
16.	Have you had sex with someone of the same sex? If yes, how many partners have you had in the last 12 months and before the last 12 months?					
17.	Have you had sex with someone you know has hepatitis C, hepatitis B or uses injection drugs? If yes, which? _____.					
18.	Have you worked in a job where you came in contact with human blood/fluids? If yes, what job?					
19.	Have you ever been in jail?					
	Did you engage in any 'risky' behaviors while in jail: tattooing, body piercing, injection drug use? If yes, which?					
20.	Have you spent any time in a group living home (e.g., psychiatric hospital, group home, halfway house)? If yes, were you a resident or an employee? _____.					
	While there, did you share any personal hygiene items: disposable razor, electric razor, toothbrush, nail clippers, other? If yes, which?					

**“Is there anything else that you think might have put you at risk for hepatitis infection?”**

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**8. History of Vaccination and Therapy**

**Have you had a vaccination for hepatitis A?**

Yes                       No                       Unknown

If yes, how many doses? \_\_\_\_\_ Year of the last dose: \_\_\_\_\_

**Have you had a vaccination for hepatitis B?**

Yes                       No                       Unknown

If yes, how many doses? \_\_\_\_\_ Year of the last dose: \_\_\_\_\_

**Have you ever received HBIg?**

Yes                       No                       Unknown  
If yes, date \_\_\_\_\_ (yyyy/mm/dd)

**Have you ever received therapy for Hepatitis B?**

Yes                       No                       Unknown

**Have you ever received therapy for Hepatitis C?**

Yes                       No                       Unknown

**Thank you very much for your time. Do you have any questions before we finish? If later you have any questions or concerns about this survey, please contact me (*provide contact info*).**

Return to Liza McGuinness, Research Manager  
BC Hepatitis Services  
**Fax: 604-707-2420**  
Phone: 604-707-2433  
655 West 12<sup>th</sup> Ave,  
Vancouver, BC V5Z 4R4