The Ottawa Hospital | L'Hôpital d'Ottawa

REGIONAL HEPATITIS PROGRAM

Baseline Information/ Nursing Intake Form

Date: YEAR / MM / DD
Patient's Name: _____
Gender: M F Transgender (circle)
Accompanied: yes/ no
If yes, specify: _____

Height: _____

Weight: _____

Race: *Black* □ *White* □ *First Nations* □ *Asian* □ *East Indian* □ *Indian Subcontinent* □ *Caribbean* □ *Hispanic/Latin American* □ *Middle Eastern/Arab* □ *Eastern Europe* □ *Western Europe* □ *Unknown* □

Country of Birth: _____ Year arriving in Canada: _____

Primary country of residence before age 10: _____

Country of Citizenship: _____ Languages: _____

Family MD / Phone(s): _____

Specialists(s) / Phone: _____Psychologist: _____

Psychiatrist: _____ Social Worker: _____

Past Travel: (last five years, chronologically by year and/or month, with approximate time spent in each country)
Voyages passés:(cinq dernières années, chronologiquement par année et mois avec le temps approximatif passé dans chaque pays)

Trip: Voyage:	Country: Pays:	Year: Année:	Month: Mois:	Time spent: Temps passé:

Patient Name: _____

RISK FACTORS: HBV □ / HCV □ INFECTION

	Yes	Year		Yes	Year
Blood Products	□	_____	Professional Tattoo	□	_____
Vaccine in developing country	□	_____	Home Made Tattoo	□	_____
Dialysis	□	_____	High Risk Sex with Male	□	_____
Transplant Recipient	□	_____	High Risk Sex with Female	□	_____
Needle Stick Injury	□	_____	Body Piercing	□	_____
Mother Carrier HBV infection	□	_____	STIs	□	_____
Acupuncture	□	_____			
Incarceration	□	_____			
Injection Drug Use	□	_____	Year started _____ Year stopped _____		
Cocaine Snorting	□	_____	Year started _____ Year stopped _____		

ALCOHOL			
Past		**Present**	
None □ Yes □ drinks/ week		None □ Yes □	
Year started	Year stopped	drinks / day	drinks / week
TOBACCO SMOKING			
Past		**Present**	
None □ Yes □ cigarette/ day		None □ Yes □	
Year started	Year stopped	cigarettes/day	cigarettes/ week
MARIJUANA USE			
Past		**Present**	
None □ Yes □ grams/joints per day		None □ Yes □	
Year started	Year stopped	gms or joints / day	gms or joints / week

EMPLOYMENT

Full-time_____ Part-time_____ Unemployed _____ Disability _____ Ontario Works _____

WHO PAYS FOR MEDICATION?

□ Ontario Disability Support Program
□ Trillium Drug Plan
□ Private Insurance
□ Ontario Works
□ Status card
□ IFH (Interim Federal Health)
□ RAMQ
□ I pay for my medication costs myself

HOUSING

What is your current housing situation**?** □ Stable □ Unstable

If unstable, describe: _____

_____

Patient Name: _____

Have you EVER been told by a doctor, nurse, or other health care professional that you had (check all that apply)

	No, Never	Yes, in the last year	Yes, but not in the last year
a) Depression	☐	☐	☐
b) Manic-depression or bipolar disorder	☐	☐	☐
c) Anxiety Disorder	☐	☐	☐
d) Panic attacks or panic disorder			
e) Social phobia or social anxiety	☐	☐	☐
f) Attention-deficit/ hyperactivity disorder (ADHD)	☐	☐	☐
g) Schizophrenia or psychotic episode	☐	☐	☐

Have you EVER been hospitalized for treatment of psychiatric or emotional problems?

☐ No, Never ☐ Yes, in the last year ☐ Yes, but not in the last year

Have you been in detox, hospitalized or otherwise treated for an alcohol problem?

☐ Never ☐ Yes, in the last year ☐ Yes, but more than 1 year ago

Have you been in detox, hospitalized or otherwise treated for a drug problem?

☐ Never ☐ Yes, in the last year ☐ Yes, but more than 1 year ago

LEGAL HISTORY

Have you spent time in jail? ☐ Yes ☐ No
Are you currently on probation or parole? ☐ Yes ☐ No
In the past 90 days, how many days were you in jail or prison? _____
Are you currently awaiting charges, trial, or sentence? ☐ Yes ☐ No
Are you currently serving weekends in jail? ☐ Yes ☐ No

COUNSELLING

Please check box were counseling done

Hepatitis C

☐ Transmission
- Blood to blood contact

☐ Personal Hygiene
- Sharps: razors, scissors, toothbrushes not to be shared
- Open wounds to be covered with band-aids

Patient Name: _____

Sexual Transmission

- Low risk
- Increased risk
- Condom use

Hepatitis B

- Family members tested Yes ☐ No ☐
- Vaccination for Household contacts Yes ☐ No ☐
- Vaccination for Sexual Contacts Yes ☐ No ☐

Comments:

Nurse's Name (please Print)/ Signature: _____/_____
Telemedicine site: _____
Date: YEAR / MM / DD