**Community Pharmacy** **Hepatitis C Antibody Testing Service – Clinical Record Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Individual’s details** \* indicates sections that must be completed | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
| Address |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
| Postcode |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | |
| Telephone |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
| Date of birth\* |  |  |  |  |  |  | NHS No. | | |  | |  | |  |  |  |  |  |  |  |  |  |  |
| Gender\* | Male  Female | | | | | | | | | | | | | | | | | | | | | | |
| Ethnic group | **A - White**  White - British  White - Irish  White - Any other White background | | | | | | | | | | | | **B - Mixed**  Mixed - White and Black Caribbean  Mixed - White and Black African  Mixed - White and Asian  Mixed - Any other mixed background | | | | | | | | | | |
| **C – Asian or Asian British**  Asian or Asian British - Indian  Asian or Asian British - Pakistani  Asian or Asian British - Bangladeshi  Asian or Asian British - Any other Asian background | | | | | | | | | | | | **D – Black or Black British**  Black or Black British - Caribbean  Black or Black British - African  Black or Black British - Any other Black background | | | | | | | | | | |
| **E – Chinese or other ethnic group**  Chinese  Any other ethnic group | | | | | | | | | | | | | | | | | | | | | | |
| Country of birth |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
| GP practice |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |
| Date of test\* | / / | | | | | | | | | | | | | | | | | | | | | | |
| Test used\* | InTec Rapid Anti-HCV Test | | | | | | | | | | | | | | | | | | | | | | |
| Test result\* | Positive  Negative | | | | | | | | | | | | | | | | | | | | | | |
| Has the individual previously received treatment for hepatitis C? | | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Where the individual consents to referral, which outreach clinic would they like to be referred to?  (The individual should select a clinic from the list provided by the ODN) | | | | | | | | | | |  | | | | | | | | | | | | |
| Test undertaken by\*  (pharmacist/pharmacy technician name) | | | | | | | | | | |  | | | | | | | | | | | | |

**CONFIDENTIAL**