PRIMARY CARE HCV TREATMENT FOLLOW-UP

CDCR 7413-3 (Rev. 03/14)

Date: Time: Age: EPRD: Allergies:

SUBJECTIVE

Current HCV treatment regimen: week ___ of ___ weeks (anticipated) for genotype ____________

☐ treatment naïve ☐ treatment experienced (check: ☐ null responder ☐ partial responder ☐ relapser) ☐ HIV positive ☐ HIV negative

☐ pegylated interferon: _____mcg SubQ/wk, week ___ of ___ (anticipated) ☐ simeprevir 150 mg: one daily, week ___ of 12(anticipated)

☐ ribavirin: _______mg total daily dose, week ___ of ___ (anticipated) ☐ sofosbuvir 400 mg: one daily, week ___ of ___(anticipated)

☐ boceprevir 200mg: 4 capsules (800mg) po q 7-9 hours, week ___ of ___ weeks (anticipated)

☐ telaprevir 375mg: ☐ 2 tablets (750mg) po q 7-9 hours, week ___ of 12 weeks or ☐ 3 tablets (1125 mg) po q ____ hours, week ___ of 12 weeks

Review of systems / side effect review: (N/V/rashes/fatigue):

☐ Depression screen if on pegylated interferon:

"Over the past 2 weeks have you felt down, depressed, or hopeless?" ☐Yes ☐No

"Over the past 2 weeks have you felt little interest or pleasure in doing things?" ☐Yes ☐No

Is the patient-inmate in EOP level of care or on psychoactive medications prescribed by Mental Health? ☐Yes ☐No

(If yes to any of the above questions, refer to Mental Health (MH) for clearance for continued treatment unless already addressed by MH.)

OBJECTIVE

Physical Exam VS: HT WT BMI BP T P R ☐ MAR reviewed

General: ____________________

Skin: ☐ normal ☐ Abn/Describe ____________________

HEENT/Neck: ☐ normal ☐ Abn/Describe ____________________

Resp/CV/Abd: ☐ normal ☐ Abn/Describe ____________________

Ext/Neuro: ☐ normal ☐ Abn/Describe ____________________

Other: ____________________

Labs: ☐ see HCV Flow sheet ☐ Labs of note (if any): ____________________

ASSESSMENT/PLAN/EDUCATION

A/P: Hepatitis C treatment, week ___ of ___ ; most recent HCV viral load _____ week ___ date: ________

☐ Continue HCV treatment ☐ Stop HCV treatment; reason for discontinuation: ____________________ ; Complete CDCR 7413-4 End of Treatment Evaluation and email to CPHCSHCVQuestions@cdcr.ca.gov.

☐ Modify HCV treatment; describe: ____________________

☐ Referral sent to: ☐ Mental Health ☐ CCHCS HCV Warmline

☐ Office of Telemedicine HCV consultation ☐ Other: ____________________ ☐ RFS completed

☐ Labs ordered per protocol for week ___ (see order sheet) ☐ Other labs: ____________________

☐ Vaccinations: ☐ Hep A ☐ Hep B ☐ Influenza ☐ Pneumovax

☐ Counseled regarding: ☐ side effect management ☐ ETOH ☐ sexual contacts ☐ tattoo ☐ other: ____________________

☐ Referred to class(es): ____________________ ☐ Literature given: ____________________

☐ Other: ____________________

☐ Follow-up with: ____________________ In: _____ ☐ days ☐ weeks

Clinician Name and Title (Print): ____________________ **Date:** __________

Clinician Signature: ____________________

1. Disability Code:	2. Accommodation:	3. Effective Communication:
☐ TABE score ≤ 4.0	☐ Additional time	☐ P/I asked questions
☐ DPH ☐ DPV ☐ LD	☐ Equipment ☐ SLI	☐ P/I summed information
☐ DPS ☐ DNH	☐ Louder ☐ Slower	**Please check one:**
☐ DNS ☐ DDP	☐ Basic ☐ Transcribe	☐ Not reached* ☐ Reached
☐ Not Applicable	☐ Other*	*See chrono/notes

4. Comments: ____________________

CDCR #:

Last Name:

First Name: MI:

DOB: