

New Patient Enrolment REACH-Out Case Record Form

Record ID _____

Surname: _____ First name: _____ DOB: ___/___/___ Address: _____ _____ Postcode: _____ Phone: (H) _____ (M) _____ Medicare no: _____ MRN: _____	Enrolling GP name and address/ stamp: Source of recruitment: <input type="checkbox"/> Self-referral <input type="checkbox"/> GP initiated
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Sex: Male / Female Age of patient: _____ Country of Birth : _____ Indigenous Status: <input type="checkbox"/> Aboriginal but not Torres Strait Islander origin <input type="checkbox"/> Torres Strait Islander but not Aboriginal origin <input type="checkbox"/> Both Aboriginal & Torres Strait Islander origin <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander origin <input type="checkbox"/> Unknown	Study Site _____
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Intercurrent conditions: Type 2 Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, year of diagnosis _____ Obesity (>30kg/m ²) <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol >40g/day <input type="checkbox"/> Yes <input type="checkbox"/> No Discussion re contraception <input type="checkbox"/> Yes <input type="checkbox"/> No Dyslipidaemia (abnormal LDL or HDL) <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medication (Prescription, herbal, OTC, recreational)
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RESULTS:

Height _____ cm Weight _____ kg

Laboratory Results (or attach copy of results) Pathology Laboratory Used: _____ Date: ___/___/___

Test	Date	Result	Test	Date	Result
HCV genotype			Haemoglobin		
HCV RNA level			Platelet count		
ALT			INR		
AST			HBsAg		
Bilirubin			HBsAB		
Albumin			HBcAB		
Creatinine			Fibroscan		
eGFR			APRI		

Other Test Results _____

PATIENT CONSENT

- I acknowledge that I explained to _____ about the health risks associated with hepatitis C, the benefits of monitoring in improving disease outcomes, and that by joining REACH OUT they will undergo blood tests and attend my practice for follow up.
- The patient agrees to enrolment in REACH OUT and to the recording of pathology results and clinical information as approved by the National Ethics Application Form process and the RACGP National Research and Evaluation Ethics Committee for use in this research project. I have explained to my patient that all collected information will remain confidential and will be stored in accordance with strict privacy protection procedures. Only authorised study staff will have access to the data. Names will be removed from records and replaced with a unique study ID as soon as possible after data collection and before data analysis. Participants will not be able to be identified, either directly or indirectly, when the results of the study are reported.

GP Signature: _____ **Date:** _____

Please send completed form to WSLHD-HepatologyService@health.nsw.gov.au
 For project related queries please contact Storr Liver Unit, Westmead Hospital on 0407141139.
**** Please send copy of signed pathology request form to REACH OUT, address and email above****