MEDICAL RECORD	Report on Separation History and Physical Exam or Continuation of S.F. _____ (Strike out one line) (specify type of examination or data)

(Sign and date)

Hepatitis C Virus (HCV) Antibody Screening at Separation or Retirement Physical Examination.

Screening for the presence of antibodies to hepatitis C virus (HCV) is offered to all military service members over the age of 35 years upon retirement or separation. This screening is not mandatory.

CDC recommends HCV testing for:

- Current or former injection drug users, including those who injected only once many years ago
- Everyone born from 1945 through 1965
- Recipients of clotting factor concentrates made before 1987, when less advanced methods for manufacturing those products were used
- Recipients of blood transfusions or solid organ transplants prior to July 1992, before better testing of blood donations became available
- Chronic hemodialysis patients
- People with known exposures to HCV, such as
  - health care workers after needle sticks involving HCV-positive blood
  - recipients of blood or organs from a donor who tested HCV-positive
- People with HIV infection
- Children born to HCV-positive mothers

If you consider yourself at risk, based on an exposure to a possible source of hepatitis C virus, you should have a simple blood test for hepatitis C infection (HCV antibody test). You may request HCV testing even if you don't have a specific risk factor for infection. You will not be asked to identify any specific risk factors to justify HCV testing. HCV testing will not delay your separation or retirement.

If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on lifestyle modifications and steps to protect others from infection.

For more information please visit https://www.cdc.gov/hepatitis/hcv

Circle one of the following:

No - I do not want to be tested for hepatitis C. Yes - I want to be tested for hepatitis C.

If you mark "yes" please Walk In to the laboratory Mon-Fri 0700-1530. You are not required to fast.

Indicate by your signature that you understand the foregoing statement.

SIGNATURE: _____ DATE: _____

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first,middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.
Name - last, first, middle Grade/Rank/Rate DTHC	REPORT ON _____ OR CONTINUATION OF _____	