Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(name, DOC #, birthdate)

FACILITY

HEPATITIS C TREATMENT CONSENT

Please initial that you understand and agree to each line item.

1. _____ I will be evaluated for medication therapy to treat my hepatitis C. It may be determined that medication is contraindicated.

2. _____ I will be placed on a "Medical Hold" to assure my care is appropriately managed, that all tests and consults are done in a timely manner, and that I have access to needed care if I have side effects. I will not be eligible for transfer to a work release until I have completed the entire treatment course. I may have to be transferred to another facility for part of my evaluation or treatment.

3. _____ I may need a FibroScan® exam (a non-invasive test to determine the amount of scarring in the liver) or liver biopsy to complete the evaluation.

4. _____ It may be necessary for me to disclose my Hepatitis C treatment to my chemical dependency/substance use disorder treatment providers, therapeutic community, or classification staff to accommodate treatment and programming schedules.

5. _____ I will not participate in tattooing during evaluation or treatment.

6. _____ I understand that even if this treatment gets rid of my Hepatitis C infection, I can get the infection again.

7. _____ There is a very small, but real possibility I can die from this treatment, especially if I have very advanced liver scarring.

8. _____ I can take acetaminophen (Tylenol®) to try to make symptoms, like headache and joint pains, better, but I should not exceed 2,000 mg per day. I should spread out my activities, allowing daily rest periods. I will ask my doctor before taking any other over-the-counter pain medications (for example: Motrin®, ibuprofen, Naproxen®).

9. _____ Treatment involves taking pills by mouth every day. I agree to take EVERY pill when I am supposed to.

10. _____ I agree to periodic blood tests to check how well the medication is working.

11. _____ I agree to scheduled check-ups with my practitioner to evaluate my overall health, side effects of the medicines, and have any questions answered.

12. _____ Medication, lab work, and practitioner check-ups may be required for up to 6 months. In addition, I will need to have periodic follow-up lab work for 3 months following completion of treatment. My type of Hepatitis C virus and the degree of scarring in my liver will determine the length of treatment and medications used.

13. _____ I will not take any medication that is not prescribed for me (or approved in writing for me to purchase from store) during the evaluation or while I take the Hepatitis C medications. If I do not comply, I may be dropped from the Hepatitis C program.

14. _____ Random drug screens may be ordered by my practitioner during evaluation and during Hepatitis C treatment. I agree to not drink any beverage or medicine containing alcohol during the evaluation or while I am in treatment. I agree not to use any illegal drugs during the evaluation or while I am in treatment. If I break this rule, I will be expected to willingly participate in and complete chemical dependency treatment.

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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15. _____ Ribavirin used in the treatment of Hepatitis C may cause birth defects. Female patients should avoid getting pregnant and avoid breastfeeding while being treated with this medication. Male patients being treated with ribavirin should avoid getting a woman pregnant. Both sexes must use at least two methods of contraception during treatment and for six months after the last treatment dose to prevent birth defects. If I am released during this period of time, I will be responsible for ensuring appropriate contraception.

16. _____ If I want to have an extended family visit with a spouse or domestic partner during treatment, I will need to sign an Authorization for Disclosure of Health Information. This Authorization will allow the health staff to discuss my Hepatitis C, the treatment I am getting for it, and any risks of birth defects with my spouse/state registered domestic partner. **If I do not agree to sign the release of information, I may not be granted extended family visits.**

17. _____ I will be asked to voluntarily sign an Authorization for Release of Health Information (DOC 13-035). This consent will allow the Department to request all previous health records available (documenting medical, dental, mental health, and chemical dependency history) in order to provide the best treatment for me.

18. _____ I understand that there is a chance this treatment will not work.

19. _____ If I choose to stop treatment for **any** reason, I may not be eligible for re-treatment.

☐ I understand everything that I have initialed above. I have been allowed to ask any questions about Hepatitis C treatment that I have. I have had all my questions answered to my satisfaction. I understand that if I have any more questions later on, that I should ask one of my health providers. I understand that if I do not initial next to any of the sections of this contract to show that I understand and/or agree with the statement, that I will not be eligible for treatment of Hepatitis C. I understand that if I fail to adhere to any of the terms of the contract in the future, that my medical practitioner may stop my treatment.

☐ I have received education regarding Hepatitis C and its treatment. I am not interested in Hepatitis C treatment at this time. This does not exclude me from treatment in the future.

PATIENT SIGNATURE	DATE
WITNESS (MAY BE HEALTHCARE PROVIDER WHO CONDUCTED INFORMED CONSENT)	DATE

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