The 1986-1990 Hepatitis C Claim Centre
PO Box 2370, Station D
Ottawa (Ontario) K1P 5W5
Canada
Tel: 1 877 434-0944
www.hepc8690.ca

P-HCV$F-ORF/1 **ORF**

Other Risk Factor Inquiry Form
Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PREPRINTED LABELS PROVIDED
* If you do not have the labels, call 1 877 434-0944 for instructions.

CORRECTIONS ONLY
Write any name, address or telephone number corrections below, if any corrections are necessary.

Please return this form once it is duly completed and signed along with all relevant supporting documentation.

Claimant Name: _____ Claim ID No.: _____

☐ **Date of HCV Infection Diagnosis: _____**
(Please attach lab report supporting date of diagnosis)

☐ **Other Trauma or Surgeries**

Explain trauma(s): _____

Date of trauma(s): _____

☐ Surgery date(s): _____

☐ Blood transfusion(s) date(s): _____

Name of hospital: _____

☐ Health records enclosed

☐ Transfusion records enclosed

} If the hospital records are unavailable the Administrator must obtain from the claimant or the hospital(s) documentation confirming the records have been destroyed or are unavailable.

☐ **Tattoos**

How many?: _____

Date(s): _____

Location: At home ☐ Shop ☐

Shop name and address: _____

☐ **Body Piercing (except ears)**

Body part(s): _____

How many: _____

Piercing date(s): _____

At home ☐ Shop ☐ Shop name and address: _____

☐ **Intra-Nasal Drug Use**

Drug(s) used: _____

Date(s): _____

Describe intra-nasal device: _____

Frequency: Once ☐ More than once ☐ More than 5 times ☐ More than 25 times ☐

☐ **Non Prescription Intravenous Drug Use**

Identify drug(s): _____

Time period: _____ Did you share needles? : _____

Frequency: Once ☐ More than once ☐ More than 5 times ☐ More than 10 times ☐

More than 30 times ☐

☐ **Prison/Incarceration**

Start date: _____ Release date: _____

Name of institution and location: _____

Reason: _____

Name of physician/nurse: _____

☐ **Dialysis Treatment**

Hemodialysis ☐ Peritoneal dialysis ☐

Date of dialysis: _____

Dialysis took place at: Hospital ☐ Clinic ☐ Home ☐

Certification

I certify that the information provided is true and correct. I am not making any false or exaggerated Claims to obtain benefits that I am not entitled to receive.

I understand that to provide false or misleading information will entitle the Administrator to reassess future compensation payable to me should the Administrator determine that such information was material. Reassessment may include paying back compensation paid to me.

Signature: _____ Date Signed: _____

Signature of Witness: _____ Witness: _____
(Print name)