The 1986-1990 Hepatitis C Claim Centre
P.O. Box 2370, Station D
Ottawa Ontario, Canada
K1P 5W5
1-877-434-0944

ORF

Other Risk Factor Inquiry Form

Strictly Private and Confidential

CLAIMANT PLEASE AFFIX HERE ONE OF THE PRE-PRINTED LABELS PROVIDED

*If you do not have the labels, call 1-877-434-0944 for instructions

CORRECTIONS ONLY:
Write any name and address corrections below, if any corrections are necessary:

Instructions: The risk factor questions that you must answer are specifically identified in the left margin box. Please return this form once it is duly completed and signed along with all relevant supporting documentation.

Claimant Name:_____ **Claim ID:**_____

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

☐ **Other Surgeries or Trauma**

Incident description: _____
Date of incident: _____
Surgery☐ Date(s): _____
Blood transfusion(s) ☐ Date(s): _____
Hospital: _____

Health records enclosed ☐
Transfusion records enclosed☐
} If hospital not able to provide records, have the hospital write a letter confirming this

☐ **Tattoos**

How many:_____
Date(s):_____
At home ☐ Shop ☐ include name and location_____

☐ **Body Piercing (except ears)**

Body part(s): _____
How many: _____
Piercing date(s): _____
At Home: ☐ Shop ☐ include name and location: _____

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☐ **Intra-Nasal Drug Use**

Drug(s) used: _____

Date(s): _____

Describe intra-nasal device: _____

Once ☐ More than X1 ☐ More than X5 ☐ More than X25 ☐

☐ **Non Prescription Intravenous Drug Use**

Identify drug(s):_____

Time period:_____Did you share needles ?:_____

Once ☐ More than X1 ☐ More than X5 ☐ More than X10 ☐ More than x30 ☐

☐ **Prison / Incarceration**

Start date:_____Release date:_____

Institution and location:_____

Reason:_____

Physician / Nurse at the Prison:_____

☐ **Dialysis Treatment**

Hemodialysis ☐ Peritoneal Dialysis ☐

Date of dialysis:_____

At Hospital ☐ Clinic ☐ At Home ☐

Certification Information is True

- **I certify that the information above is true and correct.**
- **I am not providing false or misleading answers.**
- **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. Re-assessment may include paying back compensation paid to me.**

Signature:_____**Date signed**:_____

Witness:_____

Please Print Name Below

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