



Hepatitis C Peri-Treatment Checklist

For Navigators

Patient: _____
 DOB: _____

Medication: _____
 Start Date: _____

	Date	Days of Treatment given	Doses Missed	Patient Signature
Provider visit completed on medication start date: YES NO Comments:				
Week 1**				
** Provider Visit Completed:		YES	NO	
Comments:				
Week 2				
Week 3				
Week 4**				
** Provider Visit Completed:		YES	NO	
** Labs Completed:		YES	NO	
Comments:				
Week 5				
Week 6				
Week 7				
Week 8**				
** Provider Visit Completed:		YES	NO	
** Labs Completed:		YES	NO	
Comments:				
Week 9				
Week 10				
Week 11				
Week 12**				
** Provider Visit Completed:		YES	NO	
** Labs Completed:		YES	NO	
Comments:				