CONSENT FOR DAA TREATMENT OF HEPATITIS C

1. I understand that I am being offered treatment for my Hepatitis C infection with Direct Acting Antiviral (DAA) medication.
2. I understand there are many side effects of DAA medications. I have been provided patient information listing potential adverse effects.
3. I understand that there is a small risk that DAA treatment may not be successful in eliminating the Hepatitis C virus.
4. I understand that if the treatment successfully eliminates the Hepatitis C virus, it does not reverse cirrhosis or prevent liver cancer.
5. I understand that Hepatitis C is a blood borne infection and I must abstain from activities that may transmit this infection to others. This includes but is not limited to tattooing, sexual activity, IV or intranasal drug use. Participation in such activities may result in the discontinuation of my treatment making future treatments less likely to succeed.
6. I understand that if I do not fully comply with taking the DAA medication every day, this increases the risk that this treatment will fail to eliminate the Hepatitis C virus and may result in the discontinuation of my treatment, making future treatments less likely to succeed.
7. I understand that frequent (typically monthly) blood tests are mandatory to receive DAA treatment. Failure or refusal to comply with this testing may result in discontinuation of my treatment making future treatments less likely to succeed.
8. I have discussed all of the above with IDOC medical staff. All my questions have been answered in terms and language that I understand.

☐ I agree to receive DAA treatment of my Hepatitis C.

☐ I decline DAA treatment of my Hepatitis C at this time.

Patient Name: ______________________________________ ID# ____________

Patient Signature: __________________________________ Date ___/___/___

Staff Signature: ____________________________________ Date ___/___/___

Institution: ________________________________

Original Scanned into ICON Medical. Copy to Hepatitis C Committee.