

Hepatitis Questionnaire

Claims Administrator:
 Consociate • Dansig
 Attn: Underwriting
 111 E. Decatur Street, P.O. Box 1068
 Decatur, IL 62525
 Phone: (888) 242-4357
 Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. Type, if known (i.e. A, B, C, Alcoholic, Chronic) _____

2. Any cause known? _____ Date of onset? _____

3. How often are liver function tests done? _____ Date and results of most recent liver function enzymes: _____

4. Any history of abnormal findings? Yes or No If yes, when and what treatment was received? _____

5. How often do you see the Doctor for follow-up? _____

6. Date of last visit to Doctor? _____ Recommendations: _____

7. Current medications:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Do you expect to be, or are you on a waiting list for a liver transplant? Yes or No
 If you are currently waiting, how long have you been on the list? _____

9. Are you being treated for any other medical condition? If yes, name condition and treatment: _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

