



Hepatitis C Program Community Referral Form

Client Name: _____ Date: _____

OHIP no. _____ D.O.B. _____

Address/contact if NFA: _____

Telephone: (day) _____ may we leave private message? Y N

Referring Program/Agency or Self Referral: _____

Reason for referral:

() support/education

() treatment

Diagnosis: Hepatitis C? confirmed _____ suspected _____

Does client have a primary care provider? Name + number

**need consent for release of information to Sherbourne Health Centre*

Known risk factors – tick all that apply:

() from endemic country (Africa, Pacific/Southeast Asia, Mediterranean)

() IVDU current or former

() blood recipient prior to 1992

() has been in jail/prison

Medical History:

Other considerations:

Has client ever seen a hepatologist or a GI specialist about their liver? Y N

Any harm reduction or adherence issues:

- () substance use
- () housing issues
- () mental health issues

Any further comments?

Language needs: English Y N Preferred Language _____

Interpreter required? Y N

Recent Blood work if available: *or see attached*

AST	ALT	Total bili	INR	Alb	HCV Antibody +/-	HCV-RNA	HAV Serology	HBV Serology	HIV

ANA	TSH	Ceruloplasmin	Fe	TIBC	ferritin

Thank you.

Please feel free to contact me with any further details:

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