

HEPATITIS C CARE TEAM

CLIENT REFERRAL FORM

CLIENT INFORMATION

Referral Date: _____

Last Name: _____

First Name: _____

DOB: dd/mm/yyyy ____/____/____

OHC#: _____

Address: _____

Primary Contact #: _____ Alternate #: _____

Source of Income: _____ Drug Plan: _____

REASON FOR REFERRAL:

- | | | |
|---|--|--|
| <input type="checkbox"/> Screening | <input type="checkbox"/> Outreach & Peer Support | <input type="checkbox"/> Intensive Case Management & Counselling |
| <input type="checkbox"/> Level II Testing | <input type="checkbox"/> Care & Treatment | |

HEPATITIS C HISTORY: *(Please provide the following if known and attach copies of results)*

Date of + HCV Antibody Test: ____/____/____

HCV Genotype: _____

Other Diagnostic Tests: _____

Viral Load: _____

ALT: _____

AST: _____

Hepatitis A Immune: __ yes __ no

Hepatitis B Immune: __ yes __ no

Can we leave a message for you at the:

- Primary Contact #
 - Alternate Contact #
- Please check if "yes."*

Risk Factors (Please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Injection Drug Use | <input type="checkbox"/> Unprotected sex where blood may be present |
| <input type="checkbox"/> Inhaling drugs | <input type="checkbox"/> Unprotected sex with HCV + partner |
| <input type="checkbox"/> Snorting drugs | <input type="checkbox"/> Unprotected sex with partner with STI |
| <input type="checkbox"/> Sharing drugs/cookers, spoons, water | <input type="checkbox"/> Multiple sex partners |
| <input type="checkbox"/> Sharing needles or syringes | <input type="checkbox"/> Sharing Personal Items with HCV + person |
| <input type="checkbox"/> Tattoos | <input type="checkbox"/> Exposure to blood at home or occupationally |
| <input type="checkbox"/> Body piercing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical trauma (fighting) | |

HEPATITIS C CARE TEAM

Comments: _____

Drug Use History & Route of Administration:

Current: _____

Past: _____

Other Medical Diagnoses:

Mental Health Diagnoses:

Medications:

Drug	Dosage	Frequency	Date Started:	Rxer:

What are the client's immediate needs? _____

Is anti-viral treatment a goal for this client?

Yes

No

Comments: _____

REFERRING AGENCY/PROVIDER

Referred by: _____ Signature: _____

Relationship to Client: _____

Contact Information: _____