London InterCommunity Health Centre

Regional HIV/AIDS Connection

HEPATITIS C CARE TEAM

CLIENT REFERRAL FORM

Referral Date: ______________________________

CLIENT INFORMATION

Last Name: ______________________________ **First Name:** ______________________________

DOB: dd/mm/yyyy ____/____/______ **OHC#:** ____ ____ ____ __

Address: ____

Primary Contact #: ______________________________ Alternate #: ______________________________

Source of Income: ______________________________ Drug Plan: ______________________________

REASON FOR REFERRAL & HEPATITIS C HISTORY

Screening
Level II Testing
Care & Treatment

Outreach & Peer Support

Intensive Case Management & Counselling

Please provide the following if known and attach copies of results

+ve HCV Antibody Test

HCV Genotype

Viral Load

Liver Enzymes

LFT's

Other

Known Hepatitis C risk factors or source of transmission: ______________________________

____

DRUG USE HISTORY:

Current: ____

Past: ____

PAST MEDICAL AND PSYCHIATRIC HISTORY:

____

____

____

MEDICATIONS:

Drug	Dosage	Frequency	Date Started:	Rxer:

REFERRER

Referred by: ______________________________ Signature: ______________________________

Relationship to Client: ______________________________

Contact Information: ____