London InterCommunity Health Centre

Regional HIV/AIDS Connection

HEPATITIS C CARE TEAM

Referral Form

Self or provider referrals accepted

General Information

Name: _____

Birthdate (DD/MM/YYYY): _____

Health Card Number: _____

Address: _____

Phone Number: _____

Source of Income: _____ Drug Plan: _____

Family Physician: _____

Phone: _____ Fax: _____

Reason for Referral:

- Screening (HCV Antibody Testing) HCV-PCR (Genotype and Viral Load/Chronic Hep C)
- Supportive Counselling and System Navigation
- Outreach and Peer Support/Community Supports
- Assistance with connection to community services
- Treatment

Hepatitis C History:

Known Hepatitis C risk factors or source of transmission (Blood transfusion, injection drug use, sharing personal hygiene items, jail, etc) AND if they have been *treated previously* (where, what medication, ordering provider):

_____

_____

Please attach the following laboratory investigations if they have been done:

- HCV antibody, Viral Load and Genotype
- HbA1C
- HIV
- Creatinine, Liver Enzymes and Liver function test
- CBC
- Hep A and B immune status + Hep B sAg and cAb
- Fibroscan
- Abdominal ultrasound

Referring Agency/Provider

Date: _____

Signature: _____ Relationship to Client: _____

Phone: _____ Fax: _____

Please fax completed form to the Hepatitis C Care Team at 519-642-1532

Updated September 2020