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 Hepatitis C)
- ☐ Supportive Counselling and System Navigation
- ☐ Treatment
- ☐ Outreach and Peer Support/Community Supports
- ☐ Assistance with connection to community services

Hepatitis C History:

Known Hepatitis C risk factors or source of transmission (Blood transfusion, injection drug use, sharing personal hygiene items, jail, etc):

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

- ☐ HCV antibody, Viral load and Genotype,
- ☐ HIV
- ☐ Creatinine, Liver enzymes and Liver function tests
- ☐ CBC
- ☐ HbA1C
- ☐ Hep A and B immune status
- ☐ 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 Mar 2017