Health PEI

Hepatitis C Virus Treatment Program – Patient Referral

Date of Referral: _____ Referring Individual: _____
(Does not need to be a healthcare practitioner)

Referring Individual Phone: _____

Patient Information		
Name:	**DOB:**	**MRN:**
Primary Contact:	**Alternate Contact:**	
Gender: F ( ) M ( ) Other ( )		
Address:		
Other health care providers involved in patients care:		
Workup bloodwork sent to lab Y ( ) N ( ) Unsure ( ) **A1C, Creatinine, eGFR, Alb, Total Bili, ALT, AST, AFP, ANA, HGB, PLT, INR, HCV Antibody, HCV Viral Load, HCV Genotype, HAV IgG Antibody, HBV Surface Antigen, Syphilis**		
Thought to be HCV positive since:	**Previously referred to the HCV program** **Y ( ) N ( ) Unsure ( )**	

Please send the completed referral form to

Provincial HCV Elimination Program:

Email: peihepc@ihis.org or Fax: 902-569-7633

For any further questions or concerns, please contact the HCV Elimination office

Phone: 902-569-7642