Health PEI
One Island Health System

HEPATITIS C VIRUS TREATMENT PROGRAM – PATIENT REFERRAL FORM

The Hepatitis C Virus Treatment Program aims to provide comprehensive care including staging and management of liver disease, treatment of chronic HCV infection when appropriate, and management of medical comorbidities.

Date of referral: DD_____/MM_____/YY_____ **Referring Clinician**: ________________________

PATIENT DEMOGRAPHICS			
Name (Last, First)			
Date of Birth	______(dd)/______(mm)/______(yy)	Gender	☐ Male ☐ Female
Medicare Number			
Address			
Daytime Contact #	( ) ______ - ________	Private Drug Plan: ( ) Yes ( ) No	
Alternate Contact #	( ) ______ - ________	Years thought to be HCV positive: ______Years Cirrhosis : ( ) Yes ( ) No	
Other consultants involved in past year:			

Mandatory Information (Enclosed unless being ordered/reordered then please circle test)

Hepatitis C PCR/ Viral Load and Genotype *(repeat if greater than 3 years)*
Hepatitis B Surface Antigen, Surface Antibody, and HIV Antibody (repeat if greater than 3 years)
Bilirubin, INR, Albumin, AST, ALT, GGT, ALP and CBC (repeat if greater than 3 months)
ECG (repeat if greater than 3 months)

Provincial Methadone Program (If applicable)	
On Treatment	3(mo)___ 6(mo)___
Stable Address	Yes___ No___
Other Comments	

Please fax back to the Provincial HCV Program Treating Centre:

☐ HCV Program Coordinator Robin Rankin at Fax#: (902) 432-8174 Phone#: (902) 439-0666