

Austin Health Hepatitis C Rapid Access to Treatment Clinic

Attention: Hepatitis C Outreach CNC
 M: 0481 909 741 | F: +61 3 9496 5883
 E: Livernurses@austin.org.au
 W: www.austin.org.au/HepC



Patient			
First Name			
Last Name			
DOB			
Medicare Number			
Street Address			
Suburb		Postcode	
Phone Mobile	()		
Email			
Identifies as:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Non-English speaker		
Interpreter required	Specify language:		

Laboratory Tests Required (provide copy of results)
<input type="checkbox"/> Full Blood Exam <input type="checkbox"/> Urea & Electrolytes <input type="checkbox"/> Liver Function Tests (MUST incl. AST) <input type="checkbox"/> HIV Ab <input type="checkbox"/> HAV IgG <input type="checkbox"/> HBV sAb, HBV sAg, HBV cAb <input type="checkbox"/> HCV RNA ^{^^} , HCV viral load, HCV genotype
^^ Must be HCV RNA detected for referral

Additional tests: (provide copy of results)
<input type="checkbox"/> Abdominal/Liver ultrasound (recommended if cirrhosis known/suspected)

Hepatitis C History:	
Hepatitis C Diagnosis Date HCV RNA detected: ____/____/____ Date HCV antibody reactive: ____/____/____	Prior Hepatitis C Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Prior treatment history:

Austin Health Hepatitis C Rapid Access to Treatment Clinic

Attention: Hepatitis C Outreach CNC
 M: 0481 909 741 | F: +61 3 9496 5883
 E: Livernurses@austin.org.au
 W: www.austin.org.au/HepC



Patient Full Name:	DOB:
<p>Intercurrent Conditions</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Renal impairment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>GORD <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypercholesteraema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chronic hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HIV <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Alcohol > 40 g/day <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Current IVDU <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (specify or attach documentation):</p>	<p>Current Medications (Prescription, herbal, OTC, recreational)</p>

NB: HCV treatment cannot be undertaken while pregnant or breastfeeding

Referring Practitioner			
Name Provider Number Address (or STAMP)			
Phone	()	Fax	()
Signature:			
Date:			

Office Use Only	
Date received:	
Specialist reviewed:	
Clinic allocation:	