The Hepatitis Foundation (NZ)
Chronic Hepatitis Referral Form

Please return to:
Free Post No 191379
Hepatitis Foundation of NZ
PO Box 647
Whakatane 3120

Fax: 07 3071266
Email: hepteam@hepatitisfoundation.org.nz
EDI: nzhepfnd

Hepatitis B ☐ **Hepatitis C** ☐

Referrer Details

Date of Referral:	**Contact phone:**	**Name, Position and Address of referrer:**

Title:	**Surname:**	**First Name(s):**	**Also known as:**
Male / Female	**Dob:**	**Ethnicity:**	**NHI:**

NZ Resident: Yes No	**Phone (Home):** **Phone (Work):**	**Mobile:** **Email:**

Postal Address: **Post code:**	**Residential:** *If different from postal*

Doctor (GP) Name & Address:

Medical History

Tests: For referral purposes the following test results are required:

☐ Liver function tests (LFT's)

Hep B
☐ HBsAg

Hep C
☐ HCV antibody
☐ HCV PCR RNA or HCV antigen

Include if available:

Hep B
☐ HBeAg
☐ anti-HBc
☐ anit-HBs

Hep C
☐ HCV Genotype

Hep B & C
☐ Ultrasound scan of liver HCV
☐ Liver biopsy
☐ FibroScan®

Estimated length of time of infection.	**Hepatitis previously treated? Yes/No:** *Please provide dates and area where treated*	**Any current history of substance abuse?**

Current alcohol intake: *No of standard drinks (Please circle)* **per day 0 - 2 2 – 6 >6** **per week < 14 >14**	**Other relevant past or present medical history (including mental health)?** *If yes, please provide details e.g. cirrhotic*	**Notification:** ☐ **Yes the patient has been notified of the referral to The Hepatitis Foundation**

Current medications? *Please list*