**THE AW MORROW GASTROENTEROLOGY & LIVER CENTRE**
**ROYAL PRINCE ALFRED HOSPITAL**

# ANTENATAL HCV REFERRAL FORM

**PLEASE FAX OR DELIVER COMPLETED REFERRAL TO HEPATITIS C CNC or Named Specialist**
**FAX: 9515 5182**

**TEL: 9515 7049**

**PATIENT LABEL**

| | |
|---|---|
| **Referring Medical Officer:** _____<br>**Contact:** _____ | **Patient Contact Details:**<br>**Home:** _____<br>**Mobile:** _____<br>**Work:** _____ |
| **Date of Referral:** _____ | **Gestational Time:** |

**Blood Results**

□ **HCV Antibody:** _____ **Date of Test:**_____

□ **HCV PCR:** _____ **Date of Test:** _____

***Please ensure both tests have been attended prior to referral***

**HCV Antibody Test** indicates past exposure to Hepatitis C.
**HCV PCR Test** detects current Hepatitis C virus in the blood.

| **Person Completing Form** | **GP Details** |
|---|---|
| **Name:** _____<br>**Signed:** _____ | **Name:** _____<br>**Address:** _____<br>**Contact:** _____ |

## Patient Consent

I understand this information will be faxed to the liver clinic nurses for review and that they will make contact with me to discuss the results.

**Patient Signed:** _____**Date:** _____