SLHD RPAH ANTENATAL HCV REFERRAL FORM

Complete and fax or email to (or call for information):

Sinéad Sheils
Nurse Practitioner Hepatology
A W Morrow Gastroenterology and Liver Centre, RPAH
Tel 02 95157661| Fax 02 95155182 | Mob 0459847555 | sinead.sheils@health.nsw.gov.au

PATIENT LABEL

Medical Officer: _____ **Contact:** _____	**Patient Contact Details:** **Home:** _____ **Mobile:** _____ **Work:** _____
Date of Referral: _____	**Expected Date of Confinement:**

*** Blood Results, prior to referral**

HCV Antibody Test indicates exposure to Hepatitis C
HCV/RNA Test detects current Hepatitis C virus infection

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

☐ **HCV/RNA:** _____ **Date of Test:** _____

Please ensure both tests have been attended prior to referral

Person Completing Form	**GP Details**
Name: _____ **Signed:** _____	**Name:** _____ **Address:** _____ **Contact:** _____

Patient Consent

I understand this information will be faxed to the hepatology nurse practitioner for review and she will make contact with me to discuss the results.

Patient Signed: _____**Date:** _____

COMMENTS: