Ontario-Wide HIV PrEP & VIRAL HEPATITIS VIRTUAL CLINIC

SHC Specialty Health Clinic

REFERRAL FORM

Overseeing Clinician: Mia Biondi, NP-PHC
PLEASE COMPLETE AND FAX TO:
226-785-0986

PATIENT NAME: _____

ADDRESS: _____

_____

PHONE: _____

Ok to contact patient at this number: ☐ Yes ☐ No

DOB: _____

OHIP: _____

INFORMATION TO REFERRERS: Please attach relevant laboratory or imaging results including ID/GI/hepatology to this referral.

REASON FOR REFERRAL:

- ☐ **HIV PrEP**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Other: (please specify)**
  _____
- ☐ **Fibroscan Only**
- ☐ **Fibroscan and Consult**

Does the patient have ascites or jaundice? Yes ☐ ☐ No

Is the patient pregnant? ☐ Yes ☐ No

If PrEP, is patient at high risk for HIV acquisition? (MSM, PWID, sex work) ☐ Yes ☐ No

Additional medical history or relevant information:

Name of Referring MD/NP:

_____

Billing #: _____

Phone #: _____

Fax #: _____

Address : _____

Date: _____

STAMP