HEPATITIS REFERRAL FORM:

OPEN TO ALL ONTARIO RESIDENTS

Cheryl Dale RN(EC) MScN AF-AASLD
Hepatology Nurse Practitioner
Phone: 519-902-2066
Fax: 519-936-7982
hepatitisclinic@rogers.com

NAME:

DOB: HC#:

ADDRESS:

PHONE:

Ok to contact patient at this #:

REASON FOR REFERRAL:

☐ Hepatitis B
☐ Hepatitis C

INFORMATION TO REFERRERS: *Please attach relevant laboratory or imaging results to this referral if available*

Does the patient have ascites or jaundice? ☐ yes ☐ no

Is the patient pregnant? ☐ yes ☐ no (due date if HBV)

Additional medical history or relevant information (attach EMR notes):

_____

_____

_____

_____

Date: _____

NAME OF REFERRING PHYSICIAN OR NP: _____

BILLING #: _____