**Primary Care Provider Referral to a Specialist**

**for Hepatitis C Treatment Evaluation**

**Directions:** Primary care providers referring a patient to a specialist for HCV treatment evaluation should provide the following medical information to the specialist prior to the first appointment. Information may be placed on the form or provided via attachment or excerpt from the medical record.

**Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: ­­­­­\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient** |  | | | | | | | | | **Date** |  | |
| Address |  | | | | | | | | | | | |
| Phone |  | | | | | | | | | Mobile |  | |
| Allergies |  | | | | | | | | | **DOB** |  | |
| Height |  | | Weight | | |  | | | | BMI |  | |
|  | | | | | | | | | | | | |
| **CONCOMITANT MEDICAL Diagnoses** | | | | | | | **Current Medications** | | | | | |
|  | | | | | | |  | | | | | |
|  | | | | | | |  | | | | | |
|  | | | | | | |  | | | | | |
|  | | | | | | |  | | | | | |
|  | | | | | | | | | | | | |
| **health maintenance** | | | | | | | | | | | | |
| Smoking | | | | | | | | | Substance Abuse | | | |
| Use of alcohol | | | | | | | | | Mental health assessment | | | |
| Substance use | | | | | | | | | Pregnancy/Contraception | | | |
| Other: | | | | | | | | | Other: | | | |
|  | | | | | | | | | | | | |
| **Reccomended Labroatroy testing prior to initial appointment with specialist** | | | | | | | | | | | | |
| HCV Genotype | Date: | | | ALT | | | | Date: | | | Creatinine | Date: |
| HCV RNA | Date: | | | AST | | | | Date: | | | Platelet Count | Date: |
| Albumin | Date: | | | Total bilirubin | | | | Date: | | | Hemoglobin | Date: |
|  | | | | | | | | | | | | |
| **ASSESSMENT OF LIVER** (COMPLETE IF AVAILABLE) | | | | | | | | | | | | |
| **Test performed** | | **Date** | | | **Findings/ Results** | | | | | | | |
| Liver biopsy | |  | | |  | | | | | | | |
| Ultrasound | |  | | |  | | | | | | | |
| Transient Elastography | |  | | |  | | | | | | | |
|  | | | | | | | | | | | | |
| **Other Recommendations/Referrals** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

Other tests that may be requested by specialist or PCP may want to perform these tests:

* prothrombin time (PT)
* international normalized ratio (INR)
* direct bilirubin
* total protein
* alkaline phosphatase (ALP)
* CBC
* HAV testing
* HBV serology screening

HAV and HBV Vaccine that maybe requested