North Lambton Community Health Centre

Referral Form

Self or provider referrals accepted

Hepatitis C / Harm Reduction Care Team

General Information

Name: ______________________________

Birthdate (DD/MM/YYYY): ______________________________

Health Card Number: ______________________________

Address: ______________________________

Phone Number: ____________________ Call or Text: ____________

Source of Income: ________________ Drug Plan: ________________

Family Physician: ______________________________

Email: ______________________________

Reason for Referral

- ☐ Hepatitis C Screening (HCV antibody testing) / Chronic Hepatitis C Testing (viral load & genotype)
- ☐ Counselling / Case Management
- ☐ Hepatitis C Treatment
- ☐ Peer Support
- ☐ Harm Reduction Services

Hepatitis C risk factors or source of transmission (if known)

- ☐ Sharing equipment for preparing and/or injecting drugs
- ☐ Sharing equipment for smoking or snorting drugs
- ☐ Hepatitis C sexual contact
- ☐ Sharing equipment for tattooing / body piercing

Please attach the following laboratory investigations if they have been done:

- ☐ HCV antibody, viral load, genotype
- ☐ HIV
- ☐ Liver enzymes / Liver function
- ☐ CBC
- ☐ Hep A and B immune status
- ☐ Fibroscan
- ☐ Abdominal ultrasound

Referring Agency/Provider:

Name / Agency: ______________________________

Signature: ____________________ Date: ____________________

Phone: ____________________ Fax: ____________________

Please fax completed form to the Hepatitis C / Harm Reduction Team at 519-786-3023