

**The Leeds Teaching Hospitals NHS Trust  
Department of Hepatology**

**Hepatitis B Referral Form**

Patient Surname	<input type="text"/>	Address:	<input type="text"/>
Patient first name:	<input type="text"/>		
Date of Birth:	<input type="text"/>		
Male <input type="checkbox"/> Female <input type="checkbox"/>	Age <input type="text"/> Years <input type="text"/>	Postcode:	<input type="text"/>
NHS number:	<input type="text"/>	Tel no (home):	<input type="text"/>
Interpreter required:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tel no (work):	<input type="text"/>
First Language:	<input type="text"/>	Tel no (mobile):	<input type="text"/>
Referring GP name:	<input type="text"/>	GP address:	<input type="text"/>
Telephone no.:	<input type="text"/>		
Date of Referral:	<input type="text"/>		
Does the patient require Transport?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Dear Hepatologist,

I would be very grateful if you could see the above patient who has been diagnosed with Hepatitis B.

Diagnosis: Hepatitis B  
Surface Antigen HBsAg  
  
e- antigen HBeAg  
  
e-antibody HBeAb  
  
HBV DNA PCR

Positive	Negative	Date First Confirmed
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Route of acquisition
Symptoms attributable to hepatitis B:
Medical history
Current medication:
Alcohol history:
Social history (please provide details of known support):
Liver biopsy (if applicable and to include date and hospital):

**Other tests:**

It would be very helpful if the tests below could either have been requested, or have been carried out, prior to this referral being sent, as the availability of this clinical information will enhance the patient pathway.

You may find it helpful to indicate on the form which tests have been done.

If possible, please enclose copies of all tests performed.

<b>TEST</b>	<b>TEST DONE?</b>
ABDOMINAL ULTRASOUND SCAN	<input type="checkbox"/>
ALPHA FETA PROTEIN	<input type="checkbox"/>
CLOTTING SCREEN	<input type="checkbox"/>
FULL BLOOD COUNT	<input type="checkbox"/>
HEPATITIS C	<input type="checkbox"/>
HEPATITIS B DNA	<input type="checkbox"/>
HIV	<input type="checkbox"/>
DELTA VIRUS	<input type="checkbox"/>
LIVER FUNCTION TESTS	<input type="checkbox"/>
UREA AND ELECTROLYTES	<input type="checkbox"/>

Additional information that you think would be useful:

Yours sincerely,

**NAME AND TITLE**

**Upon Completion, please send to:**

**Referrals Booking Service**  
 1st Floor, Ashley Wing  
 St James's University Hospital  
 Beckett Street  
 Leeds  
 LS9 7TF