The Leeds Teaching Hospitals NHS
NHS Trust

The Leeds Teaching Hospitals NHS Trust
Department of Hepatology

Hepatitis C Referral Form

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

Dear Hepatologist,

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

Diagnosis:		Yes	No	Date First Confirmed
	Hepatitis C Antibody positive: (include date confirmed)	☐	☐	
	Hepatitis C PCR RNA: (include date confirmed)	☐	☐	

Route of acquisition: (if history of current or past drug use including injecting, please give details including dates)
If history of drug use, briefly include current relevant information, such as: injecting frequency and prescribing regieme. Please include progress made and details of support (if this patient has an active care plan, please send a copy):
Symptoms attributable to hepatitis C:
Medical history (in particular any past or present psychiatric history):
Vaccination history:
Current medication:
Alcohol history:
Social history (please provide details of known support):
Liver biopsy (or fibro scan result) (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.

TEST	TEST DONE?
ABDOMINAL ULTRASOUND SCAN	☐
ALPHA FETA PROTEIN	☐
AUTOANTIBODIES	☐
CLOTTING SCREEN	☐
FERRITIN	☐
FULL BLOOD COUNT	☐
HEPATITIS B	☐
HEPATITIS C ANTIBODY	☐
HEPATITIS C PCR	☐
HIV	☐
IMMUNOGLOBULINS	☐
LIVER FUNCTION TESTS	☐
THYROID FUNTION TESTS	☐
UREA AND ELECTROLYTES	☐

Additional information that you think would be useful:

Yours sincerely,

NAME AND TITLE

Consultant Hepatologists
Dr MH Davies
Dr M Aldersley
Dr R Jones
Dr L Claridge
Dr P Tachtatzis
Dr J Dillon

Upon Completion, please send to:
Referrals Booking Service
1st Floor, Ashley Wing
St James's University Hospital
Beckett Street
Leeds
LS9 7TF