Street Health Centre

235 Wellington Street
Kingston, Ontario K7K 0B5
Telephone: 613.549.1440
Facsimilie: 613.549.7986
www.kchc.ca

HEPATITIS C REFERRAL FORM

Today's Date: _____

Last name: _____ First Name: _____ Initail: ___

DOB: _____ (y-m-d)

Do you live with someone?_____ (Friend, partner, wife, husband, child or other)

Address: _____ Apt #: _____

City: _____ Postal Code: _____

Phone: ( ) _____ Business: ( ) _____

Health Insurance #: _____ Version Code: _____

Family Physician: _____

Phone: ( ) _____ Fax: ( ) _____

Referring Physician: _____

Phone: ( ) _____ Fax: ( ) _____

Clinical Information please check box if test has been done if NOT; Test will be done at time of Appointment :

Hepatitis C – Antibody Test: _____ RNA Viral Load Test:_____

Genotype: _____

Biopsy Date: _____ Grade/Stage Date: _____

Services Requested:

Hepatitis C Pre-treatment Counselling	Yes □ No □
Drug and Alcohol Counselling/Treatment	Yes □ No □
Harm Reduction	Yes □ No □
Cirrhosis Surveillance	Yes □ No □

All appointments will be in the next available slot
All Clients/Patients can self-refer