Dartmouth-Hitchcock
MEDICAL CENTER

Phone: (603) 650-5206
Fax: (603) 650-5225

Gastroenterology and Hepatology

Outpatient Hepatitis C Consult Referral Form

Referring Provider: _____ Patient Name: _____

Office Phone: _____ DOB: _____ DHMC MR# _____

Office Fax: _____ Daytime phone # for patient: _____

Thank you for your referral to the Dartmouth Hepatology Group. We are requesting information prior to the visit to provide you and your patient with a comprehensive management plan in just a single visit to our department. You will then have the option for us to monitor treatment or to monitor treatment yourself using treatment guidelines provided by our department.

Please check one:

- ❑ I would like my patient to be evaluated and treated by the specialist at DHMC
- ❑ I would like a comprehensive management plan so that I can treat the patient locally
- ❑ The patient has been seen at DHMC Lebanon Hepatology and needs a follow up (up to date records still required)

Reason for Consult: _____

_____

Additional Symptoms:_____

_____

- ❑ All information is in eD-H or

Please check below the reports which will be faxed with this form to (603) 650-5225:

❑ Patient demographics (required)	❑ HCV RNA (required)	❑ HIV (required)	❑ Hep B cab
❑ Medication list (required)	❑ HCV Genotype (required)	❑ INR(required)	❑ Hep Bsag
❑ Office notes (required)	❑ liver panel (ast, alt, tbili, alb, alk phos) (required)		❑ Hep B sab
❑Abdominal ultrasound (if performed)*	❑ CBC with Diff (required)	❑Creat and GFR (required)	❑Hep A ab

*If Ultrasound not performed will be scheduled at the time of Dartmouth visit.

Referring physician's signature: _____ Date:_____

Thank you for your referral to Dartmouth-Hitchcock Medical Center's Section of Gastroenterology and Hepatology.