

## 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.

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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:

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Patient demographics (required)      | <input type="checkbox"/> HCV RNA (required)                                      | <input type="checkbox"/> HIV (required)           | <input type="checkbox"/> Hep B cab |
| <input type="checkbox"/> Medication list (required)           | <input type="checkbox"/> HCV Genotype (required)                                 | <input type="checkbox"/> INR(required)            | <input type="checkbox"/> Hep Bsag  |
| <input type="checkbox"/> Office notes (required)              | <input type="checkbox"/> liver panel (ast, alt, tbili, alb, alk phos) (required) |   | <input type="checkbox"/> Hep B sab |
| <input type="checkbox"/> Abdominal ultrasound (if performed)* | <input type="checkbox"/> CBC with Diff (required)                                | <input type="checkbox"/> Creat and GFR (required) | <input type="checkbox"/> 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.