VIRAL HEPATITIS B REFERRAL FORM

40 11		REFERRAL FORM	
	e return slip as soon as th	ne patient has been evaluated/enrolled t	o treatment using the information below.)
Name of the Receiving Unit:			
Telephone/Cellphone Number:		Email address:	
Facility Address:			
Name of Patient (Full name):			
First Name	Middle Name	Last Name	Suffix (Jr., III, etc)
Birthdate: (mm/dd/yyyy)	Age:	Sex at birth: □ Male □ Female	
Current Address: City/Municipality:		Province:	
Nationality:	ther·		
Is the client currently pregnant? (if femo		 No	
Date of first positive HBsAg test:	/ / /		
(mm/dd/yyyy)			
Reason/s for Referral: (check all that app	ply)		
☐ With HIV co-infection ☐	With renal impairment	☐ Persistent HBV DNA >2,000 IU/mL	☐ For lab test (HSeAg, HBV DNA, etc.)
☐ With Hepatitis C co-infection ☐	Pregnant	☐ With decompensatated cirrhosis	☐ Other:
☐ With risk for HCC ☐	Pediatric patient	☐ For initiation of treatment	
Defended Nation			
Referral Notes:			
N 61 B 6 1 1 1 1			
Name of the Referring Unit:			
Name of the referring staff:	Designation:	Signature:	Telephone/cellphone number:
Please attach a copy of	: 1. Viral Hepatitis B Case Re	eport and Care Form(s), 2. Laboratory result	s (HBsAg result, ALT/AST, Blood Count, etc. if available)
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		RETURN SLIP	
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