VIRAL HEPATITIS B REFERRAL FORM

REFERRAL FORM

(Kindly notify the Referring Unit using the ***return slip*** *as soon as the patient has been evaluated/enrolled to treatment using the information below.)*

Date of referral: *(mm/dd/yyyy)* ____________________

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 **Weight:** *(in kg.)* ______

Current Address: City/Municipality: ____________________ Province: ____________

Nationality: ☐ Filipino ☐ Other: ____________

Is the client currently pregnant? *(if female only)* ☐ Yes ☐ No

Date of first positive HBsAg test: ____ / ____ / ______
(mm/dd/yyyy)

Reason/s for Referral: *(check all that apply)*

- ☐ 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

Referral Notes:

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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 Report and Care Form(s), 2. Laboratory results (HBsAg result, ALT/AST, Blood Count, etc. if available)

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RETURN SLIP

(To be accomplished by the receiving unit. Please return to the referring unit via mail or e-mail once accomplished.)

Date when the patient was received: *(mm/dd/yyyy)* ____________________

Name of the Referring Unit: ____________________

Telephone/Cellphone Number: ____________________ **Email address:** ____________________

Facility Address: ____________________

Action Taken

- ☐ The patient was assessed in our facility
- ☐ The patient was evaluated and enrolled for treatment in our facility
- ☐ Our facility is not capable of providing assessment/treatment to the patient and was referred to:
  - Name of the facility: ____________________
  - Name of the physician: ____________________ Contact number: ____________________
- ☐ The patient deferred for treatment and was requested to return on *(mm/dd/yyyy)* ____________________ due to the following reason:
  (please specify) ____________________

Notes:

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Name of the Receiving Unit: ____________________

Name of the receiving staff:	Designation:	Signature:	Telephone/cellphone number: