Remote Consultation Request for Initiation of Hepatitis C Treatment

Please note this form is not a referral for a patient appointment. A Central Referral Service form must be completed to refer a patient.

Patient first name	
Patient surname	
Patient date of birth and sex	dd/mm/yyyy ☐ Male ☐Female
Patient residential address and postcode	

Before completing this form, please check if this patient:

Has **hepatitis B, HIV, cirrhosis, hepatocellular carcinoma** or **renal disease,** or is **pregnant?**
If **yes**, do NOT complete this form. These patients should be referred to a specialist via the Central Referral Service or privately.

Has **chronic hepatitis C**, i.e. **HCV antibody positive** and **HCV RNA positive** on **2 separate occasions >=6 months apart?**
If **no**, patient is not eligible for PBS-funded HCV treatment

FOR ATTENTION OF: Dr **Date:**

☐ Infectious disease physician ☐ Hepatologist ☐ Gastroenterologist

Note: GPs and other medical practitioners experienced in the treatment of chronic hepatitis C infection are eligible to independently prescribe hepatitis C treatment under the PBS without consulting a gastroenterologist or hepatologist or infectious diseases physician**.**

GP name	Dr		
Practice name			
Practice address		Postcode	
Phone	( )	Fax	( )
Mobile phone			
Email address			

Date of HCV diagnosis (dd/mm/yyyy): ______/______/______	**Co-morbidities** Diabetes ☐ Yes ☐ No Obesity ☐ Yes ☐ No Alcohol > 40 g/day ☐ Yes ☐ No Heart Disease ☐ Yes ☐ No
Prior Antiviral Treatment Has patient previously received any antiviral treatment? ☐ Yes ☐ No Has prior treatment included oral antiviral therapy? ☐ Yes ☐ No Prior treatment:	**Current Medications** (Prescription, herbal, OTC, recreational): Contraception (female patients only) ☐ Yes ☐ No I have checked for potential drug–drug interactions with current medications† ☐ Yes ☐ No † www.hep-druginteractions.org If possible, print and fax a PDF from this site showing you have checked drug–drug interactions.

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Laboratory Results (or attach copy of results)					
Test	**Date**	**Result**	**Test**	**Date**	**Result**
HCV genotype			Creatinine		
HCV RNA level			eGFR		
ALT			Haemoglobin		
AST			Platelet count		
Bilirubin			INR		
Albumin					

Liver Fibrosis Assessment (or attach copy of results)		
Test	**Date**	**Result**

Choose one test from below

APRI		
Calculate from AST and platelet count APRI: (AST to Platelet Ratio Index) (AST [IU/L] ÷ AST upper limit of normal [IU/L] × 100) ÷ platelet count (× 109 /L) www.hepatitisc.uw.edu/page/clinical-calculators/apri		

OR

Hepascore		
Not Medicare funded. Available at Pathwest. Patented formula combining bilirubin, GGT, hyaluronate, a-2-macroglobulin, age and sex.		

OR

FibroScan® (EchoSens, Paris)		
Not Medicare funded.		

People with APRI score≥1.0, Hepascore>0.8 or FibroScan® score ≥12.5 kPa should be referred to a specialist.

Liver Ultrasound (or attach copy of results) To examine for features of portal hypertension (splenomegaly, reversal of portal vein flow) and to exclude hepatocellular carcinoma.	
Date	**Result**

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Treatment Choice

I plan to prescribe:

Regimen	**Genotype**	**Duration (weeks)**

Patients should be monitored during treatment according to the current *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement* (www.gesa.org.au).

Information is also available at www.pbs.gov.au .

Patients must be tested for HCV RNA at least 12 weeks after completing treatment to determine outcome. Please notify the specialist below of the Week 12 post-treatment result.

Declaration by General Practitioner

I declare all of the information provided above is true and correct.

Signature:	
Name:	
Date:	

Approval by Specialist Experienced in the Treatment of HCV

☐ *I agree with the decision to treat this person based on the information provided above.*

☐ *I do NOT agree with the decision to treat this person based on the information provided above. Please refer the patient to a specialist via the Central Referral Service or privately*

Signature:	
Name:	
Date:	
Comments:	
Once completed, please return all 3 pages to Dr (GP's name), fax ( )	