IHCS
VICTORIAN INTEGRATED HEPATITIS C SERVICES

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Referral form

Hospital/clinic name

Surname **Date of referral**

Given name **Gender/Sex**

Title **Ms** **Miss** **Mrs** **Mr** **Other**

Date of birth **Country of birth**

Address

Mobile **Home**

Aboriginal and/or Torres Strait Islander **Yes** **No** **Both**

Interpreter required (preferred language)

GP name/practice

GP contact **Prison history** **Yes** **No**

I authorise

to receive clinical information relevant to the testing and treatment of viral hepatitis

Statewide Prison Program GP/healthcare clinic

Other relevant clinician

Signed Name

Verbal consent obtained by (name, service)

Scan/email form to