Central Michigan
District Health Department
Promoting Healthy Families, Healthy Communities

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Medical Director

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HEPATITIS C REFERRAL

Requesting Clinician

Name _____Phone_____

Address_____City_____State_____Zip_____

Has the patient ever been treated for Hepatitis C before? ☐ YES ☐ NO If YES, date_____

Patient Information

Name_____Age/year of Birth _____Sex_____

Health Insurance: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ No insurance

Year of HCV diagnosis: _____ ☐ Chronic (at least 6 months) ☐ Acute

Liver Status:

Calculated FIB-4 result: _____ (>3.25 considered evidence of cirrhosis)
[FIB-4>3.25 or prior cirrhosis requires confirmation and/or staging of cirrhosis- please consider liver ultrasound before referral.
Calculated APRI result: _____ (>1.5 considered evidence of cirrhosis)

Laboratory Results: ***(Attach copy of all test results)***

- HCV RNA viral load (within the past year)
- Hepatic Function Panel
- eGFR (within the past six months)
- INR
- CBC
- Hepatitis B surface AB, Ag, and core Ab, Hepatitis A ab
- HIV 1/2 AgAb

Current Medications (prescription, herbal, OTC, recreational): **Please Attach list.**

Is patient currently misusing illegal drugs or alcohol?
☐ Yes (consider MAT, SSP referral)
☐ No

Please fax completed form to 989-317-0552 Attn: Hep C Nurse Navigator

Please visit us at our website www.cmdhd.org