**FOR ATTENTION OF: Hepatology Specialist Date:**

***Please note this form is not a referral for an outpatient appointment unless the patient is assessed as unsuitable for remote consultation and GP management.***

**Note: GPs are eligible to prescribe hepatitis C treatment under the PBS, provided they are experienced in the treatment of chronic HCV infection or they prescribe in consultation with a gastroenterologist, hepatologist or infectious disease physician experienced in the treatment of chronic HCV infection.**

|  |  |  |  |
| --- | --- | --- | --- |
| GP name |  | | |
| GP suburb |  | GP postcode |  |
| GP phone |  | GP fax |  |
| GP mobile phone |  | | |
| GP email address |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name |  | | |
| Patient date of birth |  | Gender |  |
| Patient address, suburb, PC |  | | |
|  | | Phone |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hepatitis C History**  Date of HCV diagnosis:  Known cirrhosis\* ☐ Yes ☐ No  \* Patients with cirrhosis or HBV/HIV coinfection should  be referred to a specialist | | **Intercurrent Conditions**   |  |  |  | | --- | --- | --- | | Diabetes | ☐ Yes | ☐ No | | Obesity | ☐ Yes | ☐ No | | Hepatitis B | ☐ Yes | ☐ No | | HIV | ☐ Yes | ☐ No | | Alcohol > 40 g/day | ☐ Yes | ☐ No | |
| |  |  |  | | --- | --- | --- | | Discussion re contraception | ☐ Yes | ☐ No | |
| **Prior Antiviral Treatment** | | **Current Medications**  (Prescription, herbal, OTC, recreational) |
| Has patient previously received any antiviral treatment? | ☐ Yes ☐ No |
| Has prior treatment included Boceprevir/Telaprevir/Simeprevir? | ☐ Yes ☐ No |
| I have checked for potential  drug–drug interactions with current medications† | ☐ Yes ☐ No |
| † <http://www.hep-druginteractions.org>  If possible, print and fax a PDF from this site showing you have checked drug–drug interactions. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Laboratory Results (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\*\*** | | |
| **Test** | **Date** | **Result** |
| FibroScan, and/or |  |  |
| Other (eg. Hepascore, APRI) |  |  |
| Fibroscan is currently only available in tertiary hospital clinics; Hepascore is available from Pathwest.  APRI: <http://www.hepatitisc.uw.edu/page/clinical-calculators/apri>  \*\* People with liver stiffness on FibroScan of ≥ 12.5 kPa, Hepascore > 0.8 or an APRI score ≥ 1.0 may have cirrhosis and should be reviewed by a specialist. | | |

**Treatment Choice**

1. Not suitable for remote consultation – this is a referral for specialist assessment ☐
2. Suitable for remote consultation ☐

I plan to prescribe:

|  |  |  |
| --- | --- | --- |
| **Regimen** | **Duration (weeks)** | **Genotype** |
|  |  |  |

*A current list of treatment regimes can be found on the PBS website:* [*http://www.pbs.gov.au/info/healthpro/explanatory-notes/general-statement-hep-c*](http://www.pbs.gov.au/info/healthpro/explanatory-notes/general-statement-hep-c)

Multiple regimens are available for the treatment of chronic HCV. Factors to consider include HCV genotype, cirrhosis status, prior treatment, viral load, potential drug–drug interactions and comorbidities. See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement 2016* (<http://www.gesa.org.au)> for all regimens, and for monitoring recommendations.

**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.* | |
| Signature: |  |
| Name: |  |
| Date: |  |