



**Health**  
Northern Sydney  
Local Health District

Facility: COM HKH MQE MV RNS RYD

# REMOTE HEPATOLOGY CONSULT: HBV TREATMENT

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. DD / MM / YYYY	M.O.	
ADDRESS		
		PH
M/C	FIN	
LOCATION / WARD		ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

## Hepatitis B Community s100 Prescriber Program

Initiation of patient on treatment proforma for approval by linking specialist. Please note this form is not a referral for a patient appointment.

### For the Attention of the Hepatologist

Date:

Patient First Name

Patient Surname

Date of Birth:

Gender:  M  F

Address

Postcode

### Hepatitis B History

Year of HBV Diagnosis

Transmission Risk Factor

Known Cirrhosis\*  Yes  No

Signs of Chronic Liver Disease:

- Jaundice  Hepatomegaly  
 Splenomegaly  Spider naevi

Evidence of **Decompensated** Liver Disease:

- Peripheral oedema  Ascites  
 Jaundice  
 Encephalopathy  Low albumin  
 Variceal bleeding

\* Patients with cirrhosis, hepatic decompensation or HBV/HIV co-infection should be referred to a specialist.

### Co-morbidities

- Diabetes  Yes  No  
Obesity  Yes  No  
Hepatitis C  Yes  No  
HIV  Yes  No

### Social History

- Alcohol > 40 g/day  Yes  No  
Smoker  Yes  No

If yes, pack years?

### High Risk of Liver Disease Progression

- Male  Age > 45 yrs  
 Family history of HCC  
 Co-infection with HIV → Refer to specialist  
 Co-infection with HDV  
 Presence of cirrhosis → Refer to specialist

### Prior Antiviral Treatment

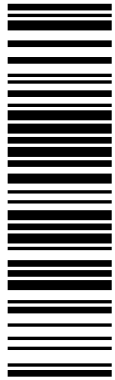
Has patient previously received any antiviral treatment?  Yes  No

If yes, which medication(s)?

- Lamivudine  
 Adefovir  
 Entecavir  
 Tenofovir

### Current Medications

(Oral, topical and inhaled: include all prescription, herbal, over the counter medications and recreational drugs)  
If insufficient space, please attach a summary list of medications.



COR5178

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BINDING MARGIN - NO WRITING

CATALOGUE NUMBER NS11742A-E AUG18/VI

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## Results

### Lab Results (or attach copy of results)

Test	Date	Result	Test	Date	Result
HBsAg		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	HBeAg		<input type="checkbox"/> Pos <input type="checkbox"/> Neg
*HBV DNA level			HBeAb		<input type="checkbox"/> Pos <input type="checkbox"/> Neg
ALT			Creatinine		
AST			eGFR		
Bilirubin			Haemoglobin		
Albumin			Platelet count		
AFP			INR		

\* HBV DNA is only funded once a year if patient is not on antiviral therapy.

### Liver Fibrosis Assessment †\*\*

Test	Date	Result	Test	Date	Result
FibroScan			APRI		

† A fibrosis assessment is recommended but not required under the PBS.

APRI. AST to platelet ratio index: [www.hepatitisc.uw.edu/page/clinical-calculators/apri](http://www.hepatitisc.uw.edu/page/clinical-calculators/apri)

\*\*People with liver stiffness on Fibroscan of  $\geq 12.5$  kPa or an APRI score  $\geq 1.0$  may have cirrhosis and should be referred to a specialist.

### Phase of Chronic Hepatitis B Infection

Phase	HBV DNA (IU/mL)	HBeAg	HBeAb	ALT	Management	My Patient's Status (tick)
<b>HBeAg +ve CHB</b>						
Immune Tolerant	> 20 000	+	-	Often normal	Monitor	
Immune Clearance	> 20 000 (fluctuating)	-	-/+	Variable/raised	Consider treatment	
<b>HbeAg -ve CHB</b>						
Immune Control	< 2000	-	+	Normal	Monitor	
Immune Escape	> 2000	-	+	Elevated	Consider treatment	

### Co-infection/Immunity Once Only Testing Required Unless High Risk

Test	Date	Result
HCV Ab		
HAV IgG Ab		Immunisation is recommended if HAV IgG Ab not detected
HDV Ab		
HIV Ab		

### HCC Surveillance

Test	Date	Result/Comment	Surveillance Interval
Ultrasound			

Patients with possible HCC found on surveillance should be referred for urgent specialist consultation.

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### Treatment Choice (Select one prescribing choice)

#### Examples of When to Seek Urgent Advice/Referral:

These situations need immediate discussion and triage prioritisation with specialist service.

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Cirrhosis (especially where suggestion of decompensation)    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Possible HCC found on surveillance                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Woman who is pregnant or planning pregnancy                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient requires immunosuppressive treatment or chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**If yes to any of the above, please forward a formal referral for this patient and an appointment will be scheduled.**

I plan to start treatment with (please tick):  Entecavir  Tenofovir

Pegylated interferon could also be considered as an option, particularly in younger people with ALT >5 x ULN who are HBeAg positive. If you think pegylated interferon is an option for this person, please discuss this with your specialist mentor before filling out the form any further.

I plan to monitor treatment with:

HBV Treatment Investigation

#### 1. Blood

FBC, COAGS, UECr, LFT a FP  
HBV sAg, sAb, HBV DNA/ Ca2+, Po4 2-

#### 2. Urine

Urine analysis, Casts, microscopy/ Urine Sediment, Urine alb/Creat ratio, Urine prot/Creat ratio

#### 3. Ultrasound Abdomen

### Declaration by General Practitioner/Medical Officer

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

GP/MO Name	Signature
Provider No	Date:
Number of patients previously initiated on HBV treatment by GP/MO (x/5):	
Address	Postcode
Phone	Fax
Mobile Phone	
Email	

Once completed please return both pages and the drug interactions and other attachments by email:

**NSLHD-RNS-HepatologyService@health.nsw.gov.au**

### Office Use Only

#### Approval by Specialist Experienced in the Treatment of HBV

- I agree with your decision to treat this person based on the information provided above
- This patient would be more suited to HBV treatment under specialist supervision. Please forward a formal referral for this patient and an appointment will be scheduled.
- Other specialist comments to GP/MO

Specialist Name Signature

Date: