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Facility: COM HKH MQE MVH RNS RYD

FAMILY NAME	MRN				
GIVEN NAME	MALE	FEMALE			
D.O.B. DD / MM / YYYY	М.С	0.			
ADDRESS					
	PH				
M/C	FIN				
LOCATION / WARD		ADM DD / MM / YYYY			

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

HEPATITIS B IN PREGNANCY REFERRAL

- A referral is mandatory and sent to the liver clinic
- · Refer all HBsAg positive pregnant women to Liver Clinic for case management of mother and infant
- · Women from 23 weeks gestation are classified as urgent referrals

Liver Clinic Contacts

Please email or fax to Liver Clinic at RNSH. The patient will be contacted for an appointment after the referral is received. Department of Gastroenterology and Hepatology

Level 4, Acute Services Building, St Leonard's, NSW, 2065

Tel: (02) 9463 2463 Fax: (02) 9463 2041

Email: NSLHD-RNS-HepatologyService@health.nsw.gov.au

For urgent referrals or advice please contact: CNC (Mon-Fri)

Patient Deta	ails										
Referral Hosp	oital:										
RNS	Hornsby	Northern Be	eaches	Ryde	Oth	ers					
Patient Conta	act Phone Number										
Interpreter Re	equired:	Yes No	o Language	е							
Referral											
Dear Director of Hepatology, Senior Staff Specialist,											
Thank you for	r reviewing				_who is	weeks	gestation with EDB://	,			
Referring Me	dical Officer:										
Name Sig						Signature					
DesignationP						Provider No					
Date:/	/										
Contact Deta	ils										
Test Results Required for Liver Clinic											
	pelow results with te which patholog		or order tests ar	nd cc Liv	ver Clinic, Le	vel 4 Acu	ite Services Building, RNSH				
Pathology	/ North (preferable	e) Do	ouglass Hanly N	Moir	Laverty	(Others				
Serology			Result				Date/Weeks of Gestation				
Hepatitis B su	urface antigen										

Hepatitis B surface antibody

Hepatitis B e-antigen

Hepatitis B e-antibody

Hepatitis B virus DNA

Hepatitis B core antibody

ALT

HEPATITIS BIN PREGNANCY REFERRAL