Northern Sydney Local Health District

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ 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

Facility: COM HKH MQE MVH RNS RYD

REMOTE HEPATOLOGY CONSULT: HCV TREATMENT

COR5147

Note: This form is not a referral for a patient appointment

For the Attention of the Hepatologist

Date: __ / __ / ____

Note: Patients must be treated by a medical practitioner experienced in the treatment of chronic hepatitis C infection; or in consultation with a gastroenterologist, hepatologist or infectious disease physician experienced in the treatment of chronic Hepatitis C infection.

Patient First Name ..... Patient Surname .....

Date of Birth: __ / __ / ____ Gender: ☐ M ☐ F

Address ..... Postcode .....

Hepatitis C History

Date of HCV Diagnosis:

Known Cirrhosis*? ☐ Yes ☐ No

Non-pregnant (female patients) ☐ Yes ☐ No

Discussion re contraception for both male & female patients? ☐ Yes ☐ No

Prior Antiviral Treatment

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

Current Medications‡

(Oral, topical and inhaled: incl. all prescriptions, herbal, over the counter & illicit drugs). If insufficient space attach a summary page of medications.

Intercurrent Conditions

Diabetes	☐ Yes	☐ No
Obesity	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Alcohol > 40 g/day	☐ Yes	☐ No

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

‡ **www.hep-druginteractions.org** Print and attach a PDF from this site, showing you have checked drug-drug interactions.

Laboratory Results (or attached copy of results)

Test	Date	Result	Test	Date	Result
HCV genotype	__ / __ / ____		Creatinine	__ / __ / ____	
HCV RNA level	__ / __ / ____		eGFR	__ / __ / ____	
ALT	__ / __ / ____		Haemoglobin	__ / __ / ____	
AST	__ / __ / ____		Platelet Count	__ / __ / ____	
Bilirubin	__ / __ / ____		INR	__ / __ / ____	
Albumin	__ / __ / ____		Weight (kg)	__ / __ / ____	

Liver Fibrosis Assessment**

Test	Date	Result
FibroScan or	__ / __ / ____	
Other (e.g. APRI)	__ / __ / ____	

APRI, AST to platelet ratio index: www.hepatitisc.uw.edu/page/clinical-calculators/apri

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

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Treatment Choice (Select one prescribing choice)

Regimen	Genotype	Status	Duration	Select
Sofosbuvir plus Ledipasvir	1	Treatment naive – no cirrhosis HCV RNA < 6 x 10^6 IU/mL	8 weeks	☐
	1	No cirrhosis	12 weeks	☐
Sofosbuvir plus Daclatasvir	1	No cirrhosis treatment – naive	12 weeks	☐
	1	No cirrhosis treatment – experienced	12 weeks or 24 weeks	☐ ☐
Sofosbuvir plus Daclatasvir	3	No cirrhosis	12 weeks	☐
Sofosbuvir plus Ribavirin	2	No cirrhosis	12 weeks	☐
Paritaprevir/Ritonavir plus Ombitasvir plus Dasabuvir	1b	No cirrhosis	12 weeks	☐
Paritaprevir/Ritonavir plus Ombitasvir plus Dasabuvir ☐ Ribavirin	1a	No cirrhosis	12 weeks	☐
Grazoprevir-Elbasvir	1 or 4	Naive – no cirrhosis	12 weeks	☐
	1b	Treatment experienced – no cirrhosis	12 weeks	☐
Grazoprevir-Elbasvir ☐ Ribavirin	1a or 4	Treatment experienced – no cirrhosis	16 weeks	☐
Sofosbubir-Velpatasvir	1, 2, 3, 4, 5 or 6	Treatment naive – no cirrhosis	12 weeks	☐
		Treatment experienced – no cirrhosis	12 weeks	☐

Patients should be monitored during treatment according to the Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (www.gesa.org.au). Information is also available at: www.pbs.gov.au/info/healthpro/explanatory-notes/general-statement-hep-c

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/Medical Officer

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

GP/MO Name .....

Address Postcode .....

Phone ..... Fax .....

Mobile Phone ..... Email .....

Signature ..... Date: __ / __ / ____

Once completed please return both pages and the drug interactions and other attachments by email:
NSLHD-RNS-HepatologyService@health.nsw.gov.au

Approval by Specialist Experienced in the Treatment of HCV (Office Use Only)

☐ I agree with your decision to treat this person based on the information provided above

☐ This patient would be more suited to HCV treatment under specialist supervision. Please forward a formal referral for this patient and an appointment will be scheduled.

Name ..... Signature .....

Designation ..... Date: __ / __ / ____