NSW GOVERNMENT Health
Northern Sydney Local Health District

Facility: COM HKH MQE MV RNS RYD

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

HOSPITAL USE ONLY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REMOTE HEPATOLOGY CONSULT: HBV TREATMENT

COR5178

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 illicit drugs)
If insufficient space, please attach a summary list of medications.

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CATALOGUE NUMBER NS11742A-E JAN22/V3

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Results

Lab Results (or attach copy of results)

Test	Date	Result	Test	Date	Result
HBsAg		☐ Pos ☐ Neg	HBeAg		☐ Pos ☐ Neg
*HBV DNA level			HBeAb		☐ Pos ☐ 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.hepatit1sc.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.

Phase of Chronic Hepatitis B Infection

Phase	HBV DNA (IU/mL)	HBeAg	HBeAb	ALT	Management	My Patient's Status (tick)
HBeAg +ve	**CHB**					
Immune Tolerant	> 20 000	+	–	Often normal	Monitor	
Immune Clearance	> 20 000 (fluctuating)	–	-/+	Variable/raised	Consider treatment	
HbeAg -ve	**CHB**					
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)	☐ Yes	☐ No
Possible HCC found on surveillance	☐ Yes	☐ No
Woman who is pregnant or planning pregnancy	☐ Yes	☐ No
Patient requires immunosuppressive treatment or chemotherapy	☐ Yes	☐ 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:

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