

Please fill in online or return to:

Free Post No 191379

Hepatitis Foundation of NZ

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EDI: nzhepfnz

# The Hepatitis Foundation of New Zealand

REFERRAL & ENROLMENT FORM



## Self-Enrolment

## Reason for referral: Chronic Hepatitis B

**Tests: For referral purposes, the following test result is required:**

### Hepatitis B

- Hepatitis B surface Antigen (**HBsAg**)  
(Results should show a "Detected" or "Positive" result)

**Include if available:**

- |   |   |
|---|---|
| <input type="checkbox"/> Liver function Tests (LFT's) | <input type="checkbox"/> Ultrasound scan of liver |
| <input type="checkbox"/> Alpha-fetoprotein (AFP)      | <input type="checkbox"/> Liver biopsy             |
| <input type="checkbox"/> Hepatitis e Antigen (HBeAg)  | <input type="checkbox"/> FibroScan                |
| <input type="checkbox"/> HBV DNA                      |   |

## Referrer Details (if not self-enrolment)

Date of Referral:

Name, Address & Phone no. of referrer:

Notification:  Yes, the patient has been notified of the referral to The Hepatitis Foundation of New Zealand

## Patient Details:

Title:		Surname:		First Name(s):		Also known as:	
Male / Female		DOB:		Ethnicity:		NHI:	
Postal Address:				Residential: <i>If different from postal</i>			
Post code:							
NZ Resident:		YES	NO	Phone (Home):		Mobile:	
				Phone (Work):		Email:	
Correspondence by email ( <i>printer required</i> )			YES	NO			

Doctor (GP) Name & Address:

## Consent (FOR PATIENTS ONLY)

**I give consent to register with the National Hepatitis Follow-up Programme managed by The Hepatitis Foundation and if required a referral to a clinical specialist for further hepatitis assessment.**

I understand that no information about my condition will be released to anyone except for those health professionals involved in carrying out this programme, including GP's, specialist and officers of the Ministry of Health who are responsible for monitoring the programme, without my signed consent.

Patient signature (Parent/Guardian if under 18):

Date:

## Medical History (circle or list)

Diabetes	Hypertension (BP)	Others (list):
Renal	Respiratory (Asthma)	
Chronic Pain	Mental Health	

Current medications or herbal supplements? *Please list*