The Hepatitis Foundation of New Zealand

Referral & Enrolment Form

Fill out online:

www.hepatitisfoundation.org.nz/refer

Return via: FREEPOST No 191379
Hepatitis Foundation of New Zealand, PO Box 647, Whakatāne 3120
EMAIL: hepteam@hfnz.nz EDI: nzhepfnd FREECALL: 0800 33 20 10

Reason for referral: Chronic Hepatitis B

◯ Self Referral ◯ Referral from Health Provider ◯ Referral from Refugee Centre

(For acute hepatitis B, please notify the local Medical Officer of Health and follow your regional health pathway)

Tests for referral (required):

◯ Hepatitis B surface Antigen (HBsAg)

(Results should show a Detected or Positive result)

Include if available (from last 2 years):

◯ Liver Function Tests (LFT) ◯ Fibroscan ◯ Liver Ultrasound

◯ Alpha-fetoprotein (AFP) ◯ HBV DNA

◯ Hepatitis B Serology - HBsAg, HBeAg, Anti-HBc, Anti-HBs

Referrer details:

Name:

Address:

Date of referral: / /

Clinic Name:

Phone:

Email:

◯ Yes, the patient has been notified of the referral to HFNZ

Patient details:

Title:

First Name:

Last Name:

Also known as:

Email:

Gender:

DOB: / /

Ethnicity:

NHI:

Country of Birth:

Residental Address:

Postal Address:

Correspondence by email: ◯ Yes ◯ No

Home Phone:

Mobile:

NOK Contact:

Relationship:

Interpreter Required:

◯ No ◯ Yes

Language:

Dialect:

Any difficulties with reading/writing? ◯ Yes ◯ No

Immigration Status:

◯ NZ Resident/Citizen ◯ Work Visa

◯ Non-Resident ◯ Refugee

◯ Student Visa ◯ Other

Doctor GP:

◯ Same as Referrer

Name:

Address:

Clinic Name:

Phone:

Community Health Navigator(s) *(for refugee referrals)*

Name:

Contact:

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 GPs, specialists and officers of the Ministry of Health who are responsible for monitoring the programme, without my signed consent.

Patient Signature: Date:

(Parent/Guardian if under 18)

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MEDICAL HISTORY *Please List:*

CURRENT MEDICATIONS & HERBAL SUPPLEMENTS *Please List:*

HBV SEROLOGY OF THE FAMILY MEMBERS *if available (HBsAg, HBeAg, Anti-HBs,Anti-Hbc)*

HEP B VACCINATION HISTORY OF THE FAMILY MEMBERS *if available*