**Community Pharmacy** **Hepatitis C Antibody Testing Service - Viral Hepatitis Referral Form**

| To (ODN) |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Individual’s details: | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | | | | |
| Address  (If of no fixed abode, the pharmacy address can be used) |  | | | | | | | | | | | | | |
| Date of birth | / / | NHS number  (if known) |  |  |  |  |  |  |  |  |  |  |  |  |
| Phone number |  | | | | | | | | | | | | | |

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| --- | --- |
| The above individual was the subject of a Hepatitis C Antibody Test, with a positive result, conducted on: / / | |
| They have previously received treatment for hepatitis C | Yes  No |
| Which outreach clinic would they like to be referred to?  (The individual should select a clinic from the list provided by the ODN) |  |

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| --- | --- | --- | --- |
| Pharmacy name |  | Telephone |  |
| NHSmail address |  | | |
| Address |  | | |

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