**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 |  |

|  |
| --- |
| 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 |  |

**CONFIDENTIAL**