Central Michigan
District Health Department
Promoting Healthy Families, Healthy Communities

Jennifer Morse, MD, MPH, FAAFP
Medical Director

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Health Officer

HEPATITIS C REFERRAL

Requesting Clinician

Name _____Phone_____

Address_____City_____State_____Zip_____

Has the patient ever been treated for Hepatitis C before? ☐ YES ☐ NO If YES, date_____

Patient Information

Name_____Age____DOB_____Sex_____

Health Insurance: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ No insurance

Year of HCV diagnosis: _____ ☐ Chronic (at least 6 months) ☐ Acute

Liver Status: if any diagnostics for the liver please send

Please order the following labs if most recent results are older than 6 months: (***Attach copy of all test results)***

- HCV Ab and Viral Load (within 1 year)
- CMP
- CBC w/Differential
- INR
- Hepatitis B surface Ab, Ag, and core Ab, Hepatitis A Ab
- HIV 1/2 AgAb

Current Medications (prescription, herbal, OTC, recreational): **Please Attach list.**

Please fax completed form to 989-317-0552 Attn: Hep C Nurse Navigator