Royal Perth Hospital Liver Service

**Remote Consultation Request**

**for Initiation of Hepatitis C Treatment Form**

**Date:** Click here to enter text.

|  |  |
| --- | --- |
| **GP Name** | Click here to enter text. |
| **GP Suburb / Postcode** | Click here to enter text. **/** Click here to enter text. |
| **GP Phone / Fax number** | Click here to enter text. **/** Click here to enter text. |
| **GP Email address** | Click here to enter text. |
|  |  |
| **Patient Name** | Click here to enter text. |
| **Patient’s Date of Birth** | Click here to enter text. |
| **Patient’s residential postcode** | Click here to enter text. |

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| **Hepatitis C History:**  **Date of HCV Diagnosis:** Click here to enter text.  **Known cirrhosis\***  **Yes**  **No**  **Hepatocellular Ca**  **Yes**  **No** | **Intercurrent conditions:**  **Diabetes**  **Yes**  **No**  **Obesity**  **Yes**  **No**  **Hepatitis B \***  **Yes**  **No**  **HIV \***  **Yes**  **No**  **Alcohol > 40g/d**  **Yes**  **No**  (> 4 standard drinks a day) |
| **Prior antiviral treatment\*:**  **Yes**  **No**  **If yes please indicate which drug(s):**  Peginterferon alpha Telaprevir  Boceprevir  Simeprevir  Other: Click here to enter text.  **Prior Treatment Response\*:**  Click here to enter text. | **Current medications:**  Click here to enter text.  **I have checked for potential Drug Interactions with existing medications\***  **Yes**  **Not applicable**    **\*** [**www.hep-druginteractions.org**](http://www.hep-druginteractions.org) |
| **Contraception required:**  **Yes**  **No**  **Contraception arranged:**  **Yes**  **No**  Note: Hep C treatment is not recommended in pregnancy or while breastfeeding. |

**\*Note: Patients with prior treatment failure, cirrhosis or HBV/HIV coinfection should be formally referred to a specialist / public clinic.**

**Patient Name:** Click here to enter text.

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| **Laboratory Results** | | |
| **Test** | **Date** | **Result** |
| **HCV Genotype** | Click here to enter a date. | Click here to enter text. |
| **HCV RNA Level** | Click here to enter a date. | Click here to enter text. |
| **ALT** | Click here to enter a date. | Click here to enter text. |
| **AST** | Click here to enter a date. | Click here to enter text. |
| **Bilirubin** | Click here to enter a date. | Click here to enter text. |
| **Albumin** | Click here to enter a date. | Click here to enter text. |
| **eGFR** | Click here to enter a date. | Click here to enter text. |
| **Haemoglobin** | Click here to enter a date. | Click here to enter text. |
| **Platelet Count** | Click here to enter a date. | Click here to enter text. |
| **INR** | Click here to enter a date. | Click here to enter text. |

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| **Liver Fibrosis Assessment** | | |
|  | **Date** | **Result\*** |
| **APRI** | Click here to enter a date. | Click here to enter text. |
| **Other (Hepascore or Fibroscan)** | Click here to enter a date. | Click here to enter text. |
| **APRI : www.hepatitisc.uw.edu/page/clinical-calculators/apri** | | |

**\*Note: People with APRI ≥ 1.0, Hepascore > 0.8 or Fibroscan ≥ 12.5 kPa should be referred to a specialist**

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| **Liver Ultrasound** | |
| **Date** | **Result** |
| Click here to enter text. | |

**Patient Name:** Click here to enter text.

**Treatment choices for people with no cirrhosis**

I plan to prescribe (please tick):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Regimen** | **Duration** | | | | **Genotype** |
| Sofosbuvir plus Ledipasvir | 8 weeks | | 12 weeks | | 1 |
| Sofosbuvir plus Daclatasvir | 12 weeks | 24 weeks | | plus ribavirin | 3 or 1 |
| Sofosbuvir plus Ribavirin | 12 weeks | | | | 2 |
| Paritaprevir/ritonavir plus Ombitasvir plus Dasabuvir | 12 weeks | | | | 1b |
| Paritaprevir/ritonavir plus Ombitasvir plus Dasabuvir plus Ribavirin | 12 weeks | | | | 1a |

**Patients should be monitored during treatment according to the ‘Australian Recommendations for the Management of HCV Infection’ www.hepcguidelines.org.au**

**Ribavirin is a Category X drug and strict contraceptive requirements apply for females, males and partners of patients.**

**Patients must be tested for HCV RNA at least 12 weeks after completing treatment to determine outcome.**

**Declaration by General Practitioner**

|  |  |
| --- | --- |
| I declare all of the information provided above is true and correct | |
| Name: | Click here to enter text. |
| Signature: |  |
| Date: | Click here to enter a date. |

**Specialist approval**

|  |  |
| --- | --- |
| I agree with the decision to treat this person based on the information provided above | |
| Name: | Click here to enter text. |
| Signature: |  |
| Date: | Click here to enter a date. |

Comments: Click here to enter text.

Please fax completed form to: (08) 9224 3388