SHELTER HEALTH
HEP C TEAM
HAMILTON

Referral Form

Fax: 289-389-7194

First name: Middle initial: Last name:

Date of Birth: Gender: Ethnicity:

Street Address:

Unit #: City: Postal Code:

Phone number: Alternate:

E-mail Address:

Employment status: Source of income: Relationship status:

SHN Doctor: Health Card Number:

Does client have any concerns that could affect his/her treatment (i.e. mental or physical health)?

Has client received a positive diagnosis for Hepatitis C Virus (HCV)? If so, when did he/she receive the diagnosis?

Referred by: _____ _____

Name Organization

_____ _____

Phone # Date

Shelter Health Hepatitis C Team Tel: 905-667-0474 Fax: 289-389-7194

Email: info.hepc@gmail.com