



**Wayside House of Hamilton - Hepatitis C Team Outreach, Treatment and Support.**

131 John Street South, Hamilton, Ontario, L8N 2C3

P: (905) 667-0474 F: (289) 389-7194

Email: [info.hepc@gmail.com](mailto:info.hepc@gmail.com)

**HOW TO MAKE A REFERRAL TO OUR CLINIC**

Thank you for referring your patient/client to our clinic for their care.

1. Fill our Referral Form below
2. Attach any blood work you may have to the Referral Form (if available).
3. Fax the referral to: **289-389-7194**. The Treatment Nurse will receive the referral and setup an appointment with your patient/client.
4. Self-referrals are welcome. Patients can drop-in at our satellite site or we can take referrals over the phone.
5. Please ensure your patient/client is aware and understands that a referral is being made to our team.
6. Please indicate if your patient/client has given permission for our clinic staff to leave a voicemail message to advise of the appointment date and time to ensure confidentiality for our mutual client is maintained.

If you have any questions or require further information, please do not hesitate to contact us. We look forward to serving your client/patient.



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## Referral Form

Client #: \_\_\_\_\_ (for Internal Use Only)

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Street Address: \_\_\_\_\_

Unit #: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Source of income :( ODSP, OW, working, CPP) \_\_\_\_\_ Relationship status: \_\_\_\_\_

SHN Doctor or Family doctor's name \_\_\_\_\_ Health card # \_\_\_\_\_

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

Is patient a SHN patient? If yes, please state SHN site patient is at \_\_\_\_\_

Which of the following priority population best describes you patient:  Indigenous Peoples  People involved with the correctional system  People who are homeless or under-housed  People who use drugs  Street-involved youth  Unknown

Date of Diagnosis: \_\_\_\_\_

Testing only: \_\_\_\_\_

Recent blood work attached: \_\_\_\_\_

Referred by: \_\_\_\_\_

Name

Organization

Phone #

Date