Please fill in online or return to:
Free Post No 191379
Hepatitis Foundation of NZ
PO Box 647, Whakatane 3120

Fax: 07 3071266
EDI: nzhepfnd

The Hepatitis Foundation of New Zealand

REFERRAL AND ENROLMENT FORM

Self-Enrolment ☐ | Reason for referral: Chronic Hepatitis B

Tests: For referral purposes, the following test result is required:

Hepatitis B

YES Hepatitis B surface Antigen (**HBsAg**)

(Results should show a "detected" or "positive" result)

Include if available:

- ☐ Liver function Tests (LFTs)
- ☐ Alpha-fetoprotein (AFP)
- ☐ Hepatitis e Antigen (HBeAg)
- ☐ HBV DNA
- ☐ Ultrasound scan of liver
- ☐ Liver biopsy
- ☐ FibroScan

Referrer Details (if not self-enrolment)

Date of Referral:	Name, Address& Phone no. of referrer:

Notification: ☐ **Yes, the patient has been notified of the referral to The Hepatitis Foundation of New Zealand**

Patient Details:

Title:	Surname:	First Name(s):	Also known as:
Male / Female	DOB:	Ethnicity:	NHI:

Postal Address: Post code:				**Residential:** *If different from postal*
NZ Resident:	**YES**	**NO**	**Phone (Home):** **Phone (Work):**	**Mobile:** **Email:**
Correspondence by email *(printer required)*		**YES**	**NO**	

Doctor (GP) Name & Address:

Consent (FOR PATIENTS ONLY)

I give consent to register with the National Hepatitis Follow-up Programme managed by The Hepatitis Foundation and if required a referral to a clinical specialist for further hepatitis assessment.

I understand that no information about my condition will be released to anyone except for those health professionals involved in carrying out this programme, including GP's, specialist and officers of the Ministry of Health who are responsible for monitoring the programme, without my signed consent.

Patient signature (Parent/Guardian if under 18): **Date:**

Medical History (circle or list)

Diabetes	**Hypertension (BP)**	**Others (list):**
Renal	**Respiratory (Asthma)**	
Chronic Pain	**Mental Health**	

Current medications or herbal supplements? *Please list*