POSITIVE WELLNESS NORTH ISLAND

Liver & HIV Services

New Form

REFERRAL FORM

FAX 250-850-2643

Phone: 250 286-7152

Last Name:	First Name:	Date of Birth: *(dd/mmm/yyyy)*
Phone:	Address:	PHN:

North Island Liver Services and ***North Island HIV Services*** provide assessment and nursing supports for patients with all liver diseases and those living with HIV.

1. **Reason for Referral:** ☐ Liver Services ☐ HIV Services

Please explain the current condition of your patient.

_____

_____

☐ **Urgent** please explain _____

2. **For Liver Services please indicate the following:**
   - ☐ Elevated liver enzymes
   - ☐ New Diagnosis Cirrhosis
   - ☐ Decompensated Cirrhosis
   - ☐ Compensated Cirrhosis Longstanding
   - ☐ Viral Hepatitis

   History of:
   - ☐ Bleeding
   - ☐ Ascites
   - ☐ Hepatic Encephalopathy

3. **Provide any other collateral or medication information we should know about:** (please attach)

_____

_____

Date of Referral:	Physician: (please print)	Physician Signature: