DEPARTMENT OF VIROLOGY
MEDICAL RESEARCH INSTITUTE
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MRI No:

Request form for Hepatitis C PCR

- **Patient information**

  Name ……………………………………………………………

  Age ……………………………………………………………..

  Address ……………………………………………………………..

  Contact Telephone number ……………………………………………………………..

- Referring Hospital ……………………………………………………………..
- Ward / BHT no: ……………………………………………………………
- Treating Clinician ……………………………………………………………..
- Indication for Hepatitis C PCR

  Before starting treatment ☐

  To monitor treatment response ☐

  Others ……………………………………………

- **Details on Hepatitis C infection**

  When was Hepatitis C infection suspected/diagnosed …………………………………

  On treatment for Hep C infection Yes/ No

  If Yes, for how long …………………………………..

  Treatment …………………………………..

- **Laboratory tests**

  Serology results ………..……………………………………………………

  Date ……………………………………………….................

  Laboratory ……………………………………………………………..

  HCV PCR done before Yes/ No

  Date of the latest test ……………………………………………………………..

  Most recent Viral load……………………………………………………………..

  Genotype if done ……………………………………………………………..

- Any other relevant medical history……………………………………………………..

Signature of the Consultant ……….………………….. Date ………………………..

Department of Virology
MRI