FIBROSCAN PROGRAM

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FIBROSCAN REFERRAL FORM

Referring Physician:

Patient's Demographics:

- Please choose a test:

☐ Fibroscan only $90 (fibrosis assessment)
☐ Fibroscan & CAP $125 (fibrosis and steatosis assessment)
☐ Hepatology Consultation (OHIP)

Please remind patient:

- Fasting 2 hours before test
- Pregnant patients are not candidates for FibroScan
- Patients with pacemaker are not candidates for FibroScan

IMPORTANT PLEASE FILL OUT BELOW

- Please see the above-named patient for a Fibroscan evaluation for:

☐ Hep B ☐ Hep C ☐ Fatty Liver

☐ Other _____

Required Laboratory Data: **IMPORTANT PLEASE FILL OUT BELOW**

Viral serology: _____

*ALT:*_____ *AST:*_____ *GGT:*_____ *ALP:*_____ *Bilirubin:*_____ *Platelet count:*_____

APPOINTMENT DATE: _____

Once the appointment is faxed back to your office-please inform the patient of the date and time. Thank you.