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J Morgan NC Hepatology/Trials
K Pietris CN Hepatology

Fibroscan® Referral

Referring Doctor

Name: _____

Address: _____

_____

Telephone: _____

**Provider number: _____

Signed: _____

Date: _____

Cc details

Dr Name: _____

Address: _____

_____

Patient Details (or patient sticker)

RAH UR No: (if app): _____

Surname: _____

Given Names: _____

DOB: _____ Sex: _____

Address: _____

Phone:

(H) _____ (W) _____

Weight: _____ kg

Height: _____ cm

Indication

ETOH ☐ Autoimmune disorder ☐

Hepatitis B ☐ T2DM ☐

Hepatitis C ☐ Deranged LFT ☐

NAFLD/NASH ☐

Medication ☐ Specify

Comorbidities ☐ Specify

Other ☐ Specify

Previous Fibroscan ○Yes ○No

Date: _____ Result: _____

Liver Biopsy ○Yes ○No Date: _____

Stage _____ Grade _____

Results (Pre scan)

ALT ____ AST ____ GGT _____

ALP ____ Platelets ____

Fibroscan Results

_____ KPa _____ IQR _____ % success

_____ CAP _____ IQR

Fibroscan Date: _____

Other comments: