FibroScan Referral

○ Urgent ○ Non-Urgent

PerCuro by sentrex

t: 250-382-6270 | f: 250-382-6273

PATIENT PROFILE

First and Last name: _____ DOB: (Month/Day/Year) _____ Sex: ○ M ○ F

PHN: _____ Phone Number _____ Weight (lbs or kg): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Reason for Referral:

○ HCV ○ HIV ○ HBV ○ MAFLD/MASH ○ ETOH ○ Elevated Enzymes ○ Other (please specify): _____

TO BE INCLUDED IN REFERRAL:

- ○ Physician Consult Letter
- ○ Recent lab work
  Within the last year to include: Hematology profile, Coag panel, ALT, AST, Total bili, GGT
- ○ Ultrasound (within the past year)
- ○ Previous LIVER BIOPSY/FIBROSCAN result, if applicable

Relevant co-morbidities (i.e. NASH, hemochromatosis, PBC, Diabetes, ETOH (drink/week), mobility issues, abdominal surgeries, etc.):

Physician Signature: _____ Date: (dd-mmm-yyyy) _____

Physician Print Name: _____ Physician Fax Number: _____

Please do not hesitate to contact our office if you have any questions or concerns.