

FibroScan Referral

Urgent Non-Urgent



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 NAFLD/NASH ETOH Elevated Enzymes Other (please specify):		

TO BE INCLUDED IN REFERRAL:

Physician Consult Letter	Ultrasound (within the past year)
Recent lab work <i>Within the last year to include: Hematology profile, Coag panel, ALT, AST, Total bili, GGT</i>	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.