FIBROSCAN
australia

REFERRAL FORMS

Patient Details Affix patient label below

Name: .....

DOB: .....

Phone: .....

Email: .....

Clinical notes and current medications

.....

.....

.....

Referring Doctor Details

Name: .....

Provider No: .....

Doctor Stamp/Signature

Date:

.....

Please fast for 4 hours prior to your procedure.

Reason for Referral:

- ☐ Alcohol
- ☐ Iron Overload
- ☐ NASH/NAFLD
- ☐ Hepatitis C
- ☐ Cystic Fibrosis
- ☐ Thalassaemia
- ☐ Fatty Liver
- ☐ Cirrhosis on imaging
- ☐ Type I or II DM
- ☐ Obesity
- ☐ Haemophilia
- ☐ Methotrexate use
- ☐ HIV
- ☐ Other .....

Refer to:

All Fibroscan results will be sent to the referring doctor.

Results include fibrosis and steatosis scores. Please note, a valid score requires a minimum of 10 scans and an IQR of ≤ 30%.

Please email reception@mvscentre.com.au if you require any further information relating to Fibroscan or interpretation.

Date booked: .....

Time booked: .....