Fibroscan® Request Form

Medicare Number: .... Health Fund: ....

Family Name: .... Given Names: ....

Date of Birth: .... / .... / .... Sex: O M O F O I

Address: ....

Phone Number: ....

Referring GP: .... Phone Number: ....

Address: ....

Date of Referral: .... / .... / .... O **Fibroscan only**

O Urgent Required by: .... / .... / .... O **Fibroscan + Outpatient OPD**

Indication for FIBROSCAN® *(tick all that apply)*

Viral Hepatitis O HBV O HCV O HIV

O ALD *Alcohol liver disease*	O NAFLD *Non-alcoholic fatty liver disease*	O ABN LFTs *Abnormal liver function tests*	O HHC *Haemochromatosis*

O Other: ....

Recent laboratory findings: .... / .... / ....

ALP:	GGT:	ALT:	AST: ....
Albumin:	Bilrubin:	Na:	INR: ....
Platelet Count:	Weight (kg):	Height (cm):	BMI: ....

Liver Biopsy:

O Yes .... / .... / .... O No O Unknown

Contraindications to FIBROSCAN® include pregnancy, pacemakers and cardiac defibrillators.

Comments:

Form completed by: Name: .... Phone: ....

Provider No: .... Fax: ....

Address: ....

Signature: .... Date: .... / .... / ....

Please fax completed form to 61 7 3319 6917

Fibroscan Bookings: 1300 270 365
Fibroscan Enquiries: 0439 gastro (427 876)
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