

☐ Alfred ☐ Sandringham ☐ Caulfield

REFERRAL FOR LIVER FIBROSIS ULTRASOUND ASSESSMENT INCLUDING FIBROSCAN®

- Attach any current reports and investigations
- Your patient will be contacted with appointment details

Enquiries: Dept of Gastroenterology T 9076 2223
Send referral to: F 9076 2194 E gastroinfo@alfred.org.au
Address: Dept of Gastroenterology, Alfred Centre
 Ground Floor, 99 Commercial Road, Melbourne, VIC, 3004

Patient Details

*mandatory fields

Family Name*				Given Name*			
Date of Birth*				Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other
Address*					Telephone*		
Medicare No				Reference No		Expiry	
<input type="checkbox"/> Bulk Bill <input type="checkbox"/> DVA <input type="checkbox"/> Other							
Interpreter	<input type="checkbox"/> Yes <input type="checkbox"/> No		Language				
Aboriginal or Torres Strait Islander							
Cultural considerations / special needs							
Contact Person		Name					
		Relationship		Telephone			

Previous investigations

Liver Biopsy	<input type="checkbox"/> Yes	Date		Fibrosis Stage	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		Inflammatory Grade	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
Liver Function	<input type="checkbox"/> Yes	Date		Total Protein			Albumin		
				Bilirubin			ALT		
				GGT			ALP		
Haematology	<input type="checkbox"/> Yes	Date		Haemoglobin		Platelets		INR	
FibroScan®	<input type="checkbox"/> Yes	Date		Result					
Indication	<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> NAFLD/MAFLD <input type="checkbox"/> IDDM / NIDDM <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Alcohol <input type="checkbox"/> PBC <input type="checkbox"/> PSC <input type="checkbox"/> Other <i>list</i>								
Clinician Estimate of Fibrosis	<input type="checkbox"/> No / minimal (FO-1) <input type="checkbox"/> Moderate (F2-3) <input type="checkbox"/> Severe / Cirrhosis (F4)								

Clinical Notes

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Referrer Details

Date of Referral				Provider No	
Name			Address		
Telephone			Fax		
Email			Copies to		

NOTE: This referral is valid for a FibroScan® assessment and an hepatic ultrasound which will be used to examine the right lobe of the liver, exclude vascular structures or other lesions which may interfere with the FibroScan® assessment and determine the skin-to-capsule distance to facilitate optimal FibroScan® probe selection. This comprehensive assessment is performed to optimize the liver fibrosis assessment and should not be considered to replace the patient's other abdominal imaging requirements or exclude other pathology. Patients will need to fast for two hours prior to undergoing FibroScan®. FibroScan® assessment may not be possible in up to 1/4 of patients with a BMI > 30kg / m² and alternative investigations may be more appropriate. For more information regarding the use of FibroScan or interpretation of results, contact the Gastroenterology Services at The Alfred.

EMR: Referrals / Referral to Gastro Diagnostics

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