

FIBROSCAN® REQUEST FORM

DEPARTMENT OF GASTROENTEROLOGY

EASTERN HEALTH

Level 2, 5 Arnold Street, Box Hill, Victoria 3128  
Phone: 98953890 Fax: 9094 9598  
**e-mail: gastro.clinics@easternhealth.org.au**

web: www.easternhealth.org.au

Patient details:

\*\* **Please Email to:** [**gastro.clinics@easternhealth.org.au**](mailto:gastro.clinics@easternhealth.org.au) **or Fax referral to: 9094 9598** \*\*

Place patient label here

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| UR number: |  |  | |  | |  | |  | |  | |  | **DOB:** \_\_/\_\_/\_\_\_ | | | | | |
| Patient name: | SURNAME | | | | | | | | | | | | First name | | | | | |
| Address line 1: |  | | | | | | | | | | | | | | | | | |
| Address line 2: |  | | | | | | | | | | | | | | | | | |
| Medicare No: |  | |  | |  | |  | |  | |  | | |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Gender: | **Male ☐** | | | | | **Female ☐** | | | | |
| Home Phone: |  |  |  |  |  |  |  |  |  |  |
| Work Phone: |  |  |  |  |  |  |  |  |  |  |
| Mobile Phone: |  |  |  |  |  |  |  |  |  |  |
| Interpreter needed: | No | yes | Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Next clinic appt: | \_\_\_/\_\_\_/20\_\_\_\_ | | | | |  |  |  |  |  |

Clinical details:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Diagnosis: | | Previous Liver Biopsy: | | | | | | | Liver Function Tests: | | | | | | Full Blood Count: | | | | | |
| Hepatitis B |  | YES: |  | Date: | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | Date: | \_\_\_/\_\_\_/20\_\_ | | | | | Date: | \_\_/\_\_\_/20\_\_ | | | | |
| Hepatitis C |  |  | | A= | | | F= | | T. Bilirubin |  |  |  |  | µmol/L | Hb |  |  |  | g/L | |
| NAFLD/NASH |  | NO: |  |  | | | | | ALP |  |  |  |  | IU/L | Platelets |  |  |  | x109/L | |
| Alcohol XS |  | Previous Fibroscan: | | | | | | | GGT |  |  |  |  | IU/L | INR |  |  |  |  | |
| PBC |  | YES: |  | Date: | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | | | ALT |  |  |  |  | IU/L | Clinical impression: | | | | | |
| PSC |  |  | | TE= Kpa | | | | IQR= | AST |  |  | \ |  | IU/L | No/Minimal fibrosis (F0-1) | | | | |  |
| Methotrexate |  | NO: |  |  | | | | | TP |  |  |  |  | g/L | Moderate fibrosis (F2-3) | | | | |  |
| Other clinical notes: | | | | | | | | | Albumin |  |  |  |  | g/L | Severe/Cirrhosis (F4) | | | | |  |

Referral details:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referrer’s Name: | Block Capitals | | Report Distribution: | | | | | | | | | Delivery Method: | | | | | | | | | | | | |
| Referrer’s Address: | Line 1 | | LMO | | |  | | Referrer | | | ✓ | Post | | | | | email | | | | FAX | | | |
|  | |  |  | |  |  | |  |  | |  |  |
| Line 2 | | MH records | | |  | | Patient | | |  | default | | | | |  | | | |  | | | |
| email: |  | | BH records | | |  | | Other | | |  | Dr……………………………………… | | | | | | | | | | | | |
| FAX: |  | | Address line 1 | | | | | | | | | | | | | | | | | | | | | |
| SIGNATURE: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Address line 2 | | | | | | | | | | | | | | | | | | | | | |
| Date: | PROVIDER NUMBER | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_/\_\_\_/20\_\_ |  |  |  | |  | |  |  | | |  | | |  | | |  | | |  | | |

Information:

Please print clearly

* FIBROSCAN® is a non-invasive method of assessing liver stiffness. It utilizes ultrasound to provide an indication of severity of liver fibrosis, but does not replace liver biopsy as a diagnostic test or the gold standard for assessment of inflammatory activity and hepatic fibrosis.
* An ultrasound may be performed prior to measurement of liver stiffness, but this procedure does not replace the need for diagnostic liver ultrasound
* In some patients an accurate measurement is not possible. Reliable measurement may not be possible in obese subjects.
* Patients do not need to alter their medications. Patients need to fast 2 hours prior to the appointment time.
* **Please complete all the fields above**. Assessment of liver stiffness should be used in conjunction with the patient’s clinical history

Patient consent for Fibroscan and Consultation (116 or 110 & 55036) fully bulk-billed:

|  |
| --- |
| *Signature: Medicare Number:* \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|

*Monash Fibroscan referral form V15 (Nov 2022)*

*Date:* \_\_\_\_\_\_\_\_\_\_

