



FIBROSCAN PROGRAM

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Gastroenterology and Liver Disease
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FIBROSCAN REFERRAL FORM

Referring Physician:

Patient's Demographics:

● Please choose the location of the appointment:

<input type="checkbox"/> 1664 Dufferin Street Toronto, ON, M6H 3M1 (no wheelchair access) Intersection: St. Clair Ave. W	<input type="checkbox"/> 108 - 4040 Finch Ave. E. Scarborough, ON, M1S 4V5 Intersection: Kennedy Road	<input type="checkbox"/> 125 – 7155 Woodbine Ave. Markham, ON, L3R 1A3 Intersection: Steeles Ave. E
<input type="checkbox"/> C4–2901 Eglinton Ave. W. Mississauga, ON, L5M 6J3 Intersection: Winston Churchill Blvd.	<input type="checkbox"/> 101–2250 Bovaird Dr. E., Brampton, ON, L6R 0W3 Intersection: Sunny Meadow Blvd. (Enter through Pharmasave)	<input type="checkbox"/> 2038 Victoria Park Ave., Scarborough, ON M1R 1V2 Intersection: Ellesmere Rd.,
<input type="checkbox"/> 2525 Old Bronte Rd., Oakville, ON L6M 4J2 Intersection: Dundas St. W.,	<input type="checkbox"/> Suite 220 -89 Queensway W., Mississauga ON L5B 2V2 Intersection: Cawthra Rd.,	<input type="checkbox"/> 308-1017 Wilson Ave., Toronto, ON M3K 1Z1 Intersection: Ellesmere Rd.,

Please select test type:

Fibroscan only \$90

Fibroscan & CAP \$125

IMPORTANT PLEASE FILL OUT BELOW

● Please see the above-named patient for a Fibroscan evaluation for:

Hep B Hep C Fatty Liver Other _____

Laboratory Data (if available):

Viral serology: _____

ALT:____ AST:____ GGT:____ ALP:____ Bilirubin:____ Platelet count:____

Once the appointment is faxed back to your office-please inform the patient of the date and time. Thank you.

APPOINTMENT TIME and DATE: _____

Please remind patient:

- **Fasting 2 hours before test**
- **Pregnant patients, patients with pacemaker and patients with ascites are not candidates for FibroScan**