# FIBROSCAN PROGRAM

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## FIBROSCAN REFERRAL FORM

**Referring Physician:**

**Patient's Demographics:**

- **Please choose the location of the appointment:**

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

**Please remind patient:**

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

**APPOINTMENT TIME and DATE:** _____