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| Referring Doctor Details: | | |
| Dr Name: | Practice Name: | |
| Practice Address: | Phone number:  Fax:  Email: | Is your practice able to provide a room for FibroScan® to be performed in-house?    Yes: No: |
| Doctor Signature: | | Date of Referral:  / / |
| Patient Details: | | |
| Family Name: | Given Name: | Date of Birth:    / / |
| Gender: Male:  Female:  Non-Binary: | Post Code: | Phone: |
| Aetiology of Liver Disease:  Hepatitis B:  Hepatitis C: | Language Spoken at Home:  Interpreter Required:  Yes: No: | Country of Birth: |
| Fibroscan cannot be performed if your patient has has ascites or is under 18 years of age.  Fibrosis Assessment recommended every 12 months for patients in immune tolerance and immune control phases (ASHM (2021): *Decision Making in Hepatitis B*) | | |
| Reason for Referral: Baseline assessment of fibrosis:  Re-Assess level of fibrosis (12 monthly)  Pre-Treatment Assessment:  Other (please specify): | | |
| Recent Blood test results <1 month if available  ALT: U/L (<200 U/L. FibroScan® contra-indicated if > 200) | | |
| Please email this completed form to: referrals@eccq.com.au  Or fax to: (07) 3844 3122 | | |

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| **Office Use only.** | |
| Date Referral received: | Appropriate referral: Yes: No: |
| Appointment date: |  |
| Location FibroScan® to be performed at: | |
| Name of BCHW to attend: or Interpreter Booked: Name: Time: | |