PERCURO CLINICAL RESEARCH LTD.

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FIBROSCAN REFERRAL

NAME		**DOB**		
PHN		**PHONE**		
ADDRESS		**Height & Weight**		**lbs**
Location	**LANGFORD** ☐		**YATES** ☐	
☐ **HCV**	☐ **HBV**	☐ **HIV**	☐ **OTHER** (please specify) _____	
CAP REQUIRED	☐ **YES** ☐ **NO**			

THE FOLLOWING IS TO BE INCLUDED IN REFERRAL:

ALL PATIENTS	
Physician Consult Letter	
Recent lab work (within past three months) Minimum required: Hematology profile, Coag panel, ALT, AST, total bili, GGT	
Ultrasound (within the past year)	
Previous LIVER BIOPSY/FIBROSCAN result, if applicable	
HCV PATIENTS ONLY	
Genotype result	
HCV RNA	
HBV PATIENTS ONLY	
HBV DNA	
EAg pos/neg	
EAb pos/neg	
HIV PATIENTS ONLY	
Viral load	
CD4	
NAFLD PATIENTS * MUST FIT ONE OF THE CRITERIA BELOW	
NAFLD Score ≥ -1.455 **Score:**	
U/S Shows steotosis and has elevated liver enzymes	
U/S Shows steotosis and has triglycerides greater than 2.5 mmol/L	

Relevant Co-morbidities (i.e. NASH, hemochromatosis, PBC, Diabetes, ETOH (drink/week) etc:

_____ **Physician Signature**

_____ **Print Name**

_____ **Physician Fax Number**

_____ **Date**

Please do not hesitate to contact our office if you have any questions or concerns.

Version Date: 13 June 2023