Latrobe Regional Hospital

FIBROSCAN CONSULTATION AND REFERRAL FORM

REFERRAL DETAILS

To: Dr. Julian Rong - Gastroenterologist
Consulting Suites 3&4
Latrobe Regional Hospital
10 Village Avenue,
Traralgon West VIC 3844

Phone: 03 5173 8111
Fax: 03 5173 8097
Mail: PO Box 424, Traralgon VIC 3844

Date: …./…./…….

Referring Doctor: ……

Provider no: ……..

Practice: ……

Contact no: ……..

Usual GP: ……

PATIENT DETAILS

Surname: ……

Given name/s: ……...…

D.O.B: ……/……./…....

Address: ……

……

Contact/s no.: ……

CLINICAL NOTES (Please attach FBC, U&E, LFT, INR)

REASON FOR REFERRAL (Please tick all that apply)

- ☐ Hepatitis C
- ☐ T2DM
- ☐ Haemochromatosis
- ☐ Alcohol
- ☐ Hepatitis B
- ☐ HIV
- ☐ Autoimmune hepatitis
- ☐ NAFLD/NASH
- ☐ Cirrhosis
- ☐ Other please describe: _____

PREVIOUS FIBROSCAN (circle) Yes / No

Date of scan: ……/……/……

Result:……

……..

PREVIOUS BIOPSY (circle): Yes / No

Date of biopsy: ……/……/……

Result: ……..

……..

LIVER FUNCTION		**CLINICAL ASSESSMENT OF LIVER SCARRING**	
Date		No / Minimal (F0 – F1)	
ALT		Moderate (F2 – F3)	
Bilirubin		Severe / cirrhosis (F4)	
Albumin			
Haemoglobin			
Platelets			
INR			