

PATIENT INFORMATION (Please fill in or affix label)

FI Ρ

Email:liverscanexpress@gmail.com			Name (Last,First):	
FIBROSCAN REQUEST FORM PLEASE FAX TO <u>437-826-4066</u>			DOB(dd/mm/yyyy): Gender:	
or email to: liverscanexpress@gmail.com			Phone: email:	
Indication for	FibroScan:			
☐ Hepatitis E	3	☐ Alcohol	☐ Abnormal liver tests	
☐ Hepatitis (C	□ PBC	☐ Suspected cirrhosis	
☐ Fatty liver		☐ Methotrexate	☐ Other:	
☐ Diabetes		☐ Obesity		
Clinical Inform	nation/Diag	nosis/Question:		
ALT A	AST	ALP Platele	ts HBV DNA	HBeAg +/-
2 (; 2)				
Referring Phy	ysician (plea	ase include fax numb	per and physicians to 'cc'):	
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Main Clinic Location: (for more location information, please contact us) 3443 Finch Ave E,Unit 209,Scarborough,ON M1W2S1

> Fasting required 3 hours prior to exam, Fee:\$125