CAN COMMUNITY HEALTH

FIBROSCAN CONSULTATION REFERRAL FORM

1231 NORTH TUTTLE AVENUE
SARASOTA, FLORIDA 34237

REFERRING PHYSICIAN:

Name: _____

Address: _____

City _____ State _____ Zip: _____

Phone: _____ Fax: _____

NPI: _____

PATIENT'S DEMOGRAPHICS:

Name: _____

Address: _____

City _____ State _____ Zip: _____

Phone: _____ Notes: _____

_____

INSURANCE INFORMATION

Insurance Company _____ Policy # _____

Group# _____ Plan Name _____

Insured _____ Relationship to patient _____ Insured's D.O.B. _____

(IF OTHER THAN PATIENT)

IMPORTANT–PLEASE FILL OUT BELOW

IMPORTANT REMINDERS:

Fasting 3 hours before test is rquired for Fibroscan at time of appointment.

NOT candidates for FibroScan:

• Pregnant patients • Patients with pacemakers • Patients with active ascites • Previous liver biopsy within 6 months

1. Please see the above-named patient for a FibroScan evaluation for: ☐ HEP B ☐ HEP C Other _____
Diagnosis Code(s) _____ _____ _____

2. ☐ Consultation and evaluation - **provide treatment** ☐ Consultation with recommendation and - **refer back**

3. Referring Physician Signature: _____

LABORATORY DATA
(IF AVAILABLE)

Viral serology: _____

ALT: _____ AST: _____ GGT: _____ ALP: _____ Bilirubin: _____ Platelet Count: _____

INTERNAL USE ONLY

Fibroscan Appointment Date _____ Appointment Time _____

Authorization/Referral: _____