Phoenix Gastroenterology and Health Services

LIVER FIBROSCAN REQUEST FORM

Referring Physician : _____ **Date :** _____

Patients Details : _____

_____

Ultrasound already done and available ☐ **Yes or** ☐ **No**

Clinical Indications (tick as appropriate) **:**

- ☐ NAFLD (Non-alcoholic Fatty Liver Disease)
- ☐ Abnormal Liver Function Test
- ☐ ALD (Alcoholic Liver Disease)
- ☐ Autoimmune Hepatitis
- ☐ Chronic Hepatitis B
- ☐ Chronic Hepatitis C
- ☐ Drug induced liver injury
- ☐ Hemochromatosis
- ☐ Liver disease unspecified
- ☐ PBC (Primary Biliary Cholangitis)
- ☐ Other (please specify)

_____

_____

PREPARATION:

FASTING FOR 3 HOURS. Wear comfortable clothes that will allow access to the right side of your rib cage. Your doctor will ask you to lie down on your back to do the test.

Contact

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(876) 929 7108 | (876) 409 0791 | (876) 281 8915 (whatsapp only)

(876) 728 2540

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Bring this procedure sheet with you on the day of your test please