



**PATIENT INFORMATION**  
(Please fill in or affix label)

**FIBROSCAN REQUEST FORM**  
**PLEASE FAX TO 647-494-3243**

**Date of request:**  
\_\_\_\_\_

**Name:** \_\_\_\_\_  
**DOB (dd/mm/yyyy):** \_\_\_\_\_  
**Gender:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Email:** \_\_\_\_\_

**Indication for FibroScan:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <b>Fatty liver</b>  | <input type="checkbox"/> <b>Alcohol</b>      | <input type="checkbox"/> <b>Abnormal liver tests</b> |
| <input type="checkbox"/> <b>HBV</b>          | <input type="checkbox"/> <b>PBC</b>          | <input type="checkbox"/> <b>Suspected cirrhosis</b>  |
| <input type="checkbox"/> <b>HCV</b>          | <input type="checkbox"/> <b>Methotrexate</b> | <input type="checkbox"/> <b>Liver screening</b>      |
| <input type="checkbox"/> <b>Other:</b> _____ |  |  |

**Clinical Information/Diagnosis/Question:**

ALT \_\_\_\_\_ AST \_\_\_\_\_ ALP \_\_\_\_\_ Platelets \_\_\_\_\_ HBV DNA \_\_\_\_\_ HBeAg +/-

**Referring Physician (please include fax number and physicians to 'cc'):**

\_\_\_\_\_

**Preferred Clinic Location:**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Toronto West (Bloor &amp; Islington)</b><br>Bloor Islington Place, #1140-3280 Bloor St. West<br>Centre Tower, 11th Floor. | <input type="checkbox"/> <b>Woodbridge</b> (#200-4610 Hwy #7 West)                  |
| <input type="checkbox"/> <b>Scarborough (Finch &amp; Kennedy)</b><br>#302 – 4040 Finch Ave.   | <input type="checkbox"/> <b>Newmarket</b> (#610-581 Davis Dr.)                      |
| <input type="checkbox"/> <b>Mississauga East</b><br>#370-1420 Burnhamthorpe Rd. East.   | <input type="checkbox"/> <b>Newmarket</b> (#216-16700 Bayview Ave.)                 |
| <input type="checkbox"/> <b>Mississauga Center (Erindale Medical Center)</b><br>1101 McBride Ave.   | <input type="checkbox"/> <b>Richmond Hill</b> (#510-330 Hwy #7 East)                |
| <input type="checkbox"/> <b>Mississauga Credit Valley</b><br>Suite 511, 2300 Eglinton Ave. West.  | <input type="checkbox"/> <b>Burlington</b> (#32-1960 Appleby Line)                  |
| <input type="checkbox"/> <b>Mississauga West GTA</b><br>Unit 18-3545 Odyssey Dr.  | <input type="checkbox"/> <b>North York</b> (#403-1100 Sheppard Ave. East)           |
|   | <input type="checkbox"/> <b>Barrie</b> (Whole Life Clinic, 30 Owen St.)             |
|   | <input type="checkbox"/> <b>Waterloo</b> (Sanguen Health Ctr., 29 Young St. East)   |
|   | <input type="checkbox"/> <b>Guelph</b> (Sanguen Health Ctr., 176 Wyndham St. North) |

Patients should fast at least 3 hrs prior to their scan. Fee for FibroScan including CAP is \$140-150 (depending on location), payable by cash, credit card, or debit. We will contact your patient directly with their appointment. Bookings also available online at [www.liverscan.ca](http://www.liverscan.ca).

For questions, call 416-268-0150 or visit [www.liverscan.ca](http://www.liverscan.ca).