UVAHealth

Charles O. Strickler Transplant Center
Liver Fibroscan Referral Form

Fax to: Greg Shifflett **Fax #: 434-924-8774**

(Please Print)

Today's date:	Name of Practice:		
Address:		Phone: ( )	Fax: ( )
Referring Provider:		**Contact Person:**	
PCP (if different from referring):			

PATIENT INFORMATION

Patient's last name: First: Middle:			Sex ☐ M ☐ F	Birth Date / /	Soc. Security Number ___-___-____
Street address:			PO Box:		Home phone: ( )
City:	State:	ZIP Code:	Work phone: ( )		Cell phone: ( )
Name Additional Contact:	Relation to Patient:		Primary phone: ( )		Cell phone: ( )
Race:	Ethnicity:		Preferred Language: Interpreter needed: ☐ Y ☐ N		Marital Status:

INSURANCE INFORMATION

(Please Include Copy of Insurance Card)

Is this patient covered by insurance?	☐ Yes	☐ No		
Please indicate primary Insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:

LIVER DIAGNOSIS INFORMATION

(Please Check All That Apply)

☐ HCV ☐ HBV ☐ Alcoholic Fatty Liver ☐ PBC ☐ PSC ☐ NASH

☐ Known Cirrhosis - Evaluate for Clinically Significant Portal Hypertension

☐ Autoimmune Hepatitis on Immunosuppression

CONTRAINDICATIONS – MUST BE VERIFIED PRIOR TO TEST SCHEDULING

☐Patient is **NOT** pregnant ☐Patient does **NOT** have an implanted electronic device

☐ Patient **USES** continuous glucose monitoring device

PLEASE INCLUDE THE FOLLOWING – MUST BE OBTAINED PRIOR TO TEST SCHEDULING

☐Most Recent LFTs (within the last 3 months) ☐Most Recent Office Notes (within the last 6 months)