



LIVER CLINIC ASSESSMENT REQUEST

Dr. Paul Marotta

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PATIENT NAME: _____

DOB (DD/MM/YY): _____

HC# : _____

ADDRESS: _____

PHONE NUMBER: _____

PHYSICIAN NAME: _____

OFFICE FAX: _____

BILLING NUMBER: _____

SIGNATURE: _____

REASON FOR REFERRAL

- | | |
|--|---|
| ☐ NAFLD/Fatty Liver Disease | ☐ Medication Risk (Methotrexate) |
| ☐ Alcohol Related Disease | ☐ PBC |
| ☐ Hepatitis C | ☐ AIH/PSC |
| ☐ Hepatitis B | ☐ Abnormal Liver Tests |
| ☐ Rule Out Cirrhosis | ☐ Other |

TYPE OF REFERRAL

☐ **HEPATIC FIBROSIS ASSESSMENT*:**

FIBROSCAN®/SHEAR WAVE (ELASTOGRAPHY) PREVIOUS VALUE: _____

☐ **CONSULTATION**

* THERE IS A FEE FOR FIBROSCAN®/SHEAR WAVE AS IS A NON INSURED OHIP SERVICE.

LAB WORK IS ACCESSIBLE THROUGH ONTARIO LABORATORY INFORMATION SYSTEM (OLIS),

PLEASE ATTACH IMAGING REPORTS ONLY.