MonashHealth

☐ Dandenong Hospital ☐ MMC – Clayton
☐ Kingston Centre ☐ MMC – Moorabbin
☐ Jessie McPherson ☐ Community Health Services
☐ Casey Hospital ☐ Cranbourne Integrated Care Centre

Unit Record Number: _____
Surname: _____
Given Name: _____
D.O.B: _____ / _____ / _____ Age: _____ Sex: _____
Address: _____
Mobile #: _____

SHF046816

Fibroscan Consultation & Referral

To: A/Prof Sally Bell
Dr Marcus Robertson, Dr Debbie Nathan,
Dr Gauri Mishra, Dr Michael Braude, Dr Thomas Worland
& Dr Ashley Bloom
Monash Medical Centre, 246 Clayton Road, Clayton

All referrals to be emailed to: fibroscan@monashhealth.org
External referrals (GP, external specialists)
Internal referrals (Monash Health Specialists)

Date: _____ / _____ / _____
Referring Doctor: _____
Provider number: _____
☐ **GP / Specialist to receive report**
GP / Specialist email:
_____
****MANDATORY Name and Provider number MUST be provided for referral to be actioned / accepted****

Reason for Referral: (please circle)

Hepatitis C	Type 2 Diabetes	Autoimmune Hepatitis	Methotrexate use	Haemophilia
Hepatitis B	Alcohol	Iron Overload	Thalassemia	Cystic Fibrosis
NAFLD	Haemochromatosis	HIV	Cirrhosis on imaging	

Other: _____

Previous Fibroscan (circle): YES / NO DATE: _____/_____/_____ Result: _____

EXTERNAL REFERRAL ONLY	INTERNAL REFERRAL ONLY		
Referring GP / Specialist Details:	Liver Biopsy (circle)	Yes	No
Address:	Date	/ /	
	Fibrosis Stage (circle)	0 1 2 3 4	
Phone:	***Liver Function***		
Clinic email:	Date	/ /	
Clinical Notes:	ALT		
	Bilirubin		
	Albumin		
	Haematology		
	Platelets		
	INR		
	Location of last blood test:		
	Clinical Assessment of Liver Scarring		
	☐ No / Minimal (F0 – F1)		
	☐ Moderate (F2 – F3)		
	☐ Severe / Cirrhosis (F4)		
Please attach copy of liver function tests, INR and FBC	**Weight (kg)**		
	Waist Circumference		

FIBROSCAN CONSULTATION AND REFERRAL MRI176

Outpatient Divider

For enquiries – Phone: (03) 9594 3546 email: fibroscan@monashhealth.org