Digestive Health CENTER
an affiliate of TDDC Texas Digestive Disease Consultants

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Fibroscan Referral Form

Please inform patient nothing to eat or drink for **3 hours prior to appointment**

Is the patient able to lay flat on bed? Yes No

Patient's preferred day to be scheduled?

Monday- Afternoon

Tuesday- Morning

Thursday- Afternoon

Reason for referral?(Diagnosis)_____

Referring Physician:_____

Please circle any/all tests patient has had done: (and fax corresponding results)

Labwork Ultrasound CT scan

Comments:_____

_____

_____

Please send all recent records- i.e. Demographics/labs/radiology/office notes
Phone: 985-446-1958/ Fax: 985-446-0121