Digestive Health CENTER

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FibroScan Referral Form
Fax to: 985-446-0121

Please inform patient that they are required to fast for **3 hours prior to appointment**

Patient Name: _____ Patient DOB: _____

Patient BMI: _____

Is patient able to lay flat on bed? YES NO

Indication for Referral (Diagnosis): _____

Referring Physician: _____

Does patient have any tests to support diagnosis (circle all that apply):

LABS ULTRASOUND CT SCAN OTHER: _____

Comments: _____

PLEASE ATTACH THE FOLLOWING TO EVERY REFERRAL:

1. Demographics / Face Sheet
2. Last progress note
3. Recent Labs
4. Recent Imaging

Thank you so much, we appreciate your referral!