UNC Hospitals GI Medicine Clinic
100 Eastowne Drive
Chapel Hill, NC 27514
Phone: 984-974-5050 Fax: 984-974-3414

HEPATOLOGY FibroScan Referral FORM

Date: _____

PATIENT INFORMATION **UNC MR# (*if known*):**

LAST NAME:	FIRST NAME:		MIDDLE NAME:
Primary phone:	Alternate phone:	Gender: F ☐ M ☐	Birth Date:
Street address:			
City:	County:	State:	Zip:

Is an interpreter needed? ☐ **Yes** ☐ **No** **If yes, what language?** _____

Main Etiology of Liver Disease ☐ **HCV** ☐ **HBV** ☐ **Alcohol** ☐ **NASH** ☐ **PBC** ☐ **PSC** ☐ **Other**_____

Patient's BMI_____

REFERRING PROVIDER INFORMATION		
Provider Name:		**Provider NPI:**
Practice Name:		
Street Address:	**City, State, Zip**	
PHONE:	**FAX:**	**EMAIL ADDRESS:**

INSURANCE INFORMATION			
POLICY HOLDER'S RELATIONSHIP TO PATIENT: ☐**SELF** ☐**PARENT** ☐**SPOUSE** ☐**CHILD** ☐**OTHER**	**LAST NAME:**		**FIRST NAME:**
SEX: F ☐ **M** ☐	**BIRTH DATE:**		**PRIMARY PHONE:**
PRIMARY INSURANCE CARRIER:	**POLICY #:**	**GROUP #:**	**EFFECTIVE DATE:**
SECONDARY INSURANCE CARRIER:	**POLICY #:**	**GROUP #:**	**EFFECTIVE DATE:**
PLEASE ENCLOSE COPY OF INSURANCE CARD			

NOTE: This request is for FIBROSCAN testing ONLY

This patient will undergo a FibroScan/ Vibration Controlled Transient Elastography assessment of liver fibrosis. A report will be generated and returned to the referring clinician with general recommendations according to the stage of liver fibrosis.

If a clinical consultation is desired, please refer the patient to the UNC Liver Center. Consultation Request Forms are available online at www.uncgi.com.