



UNC Hospitals GI Medicine Hepatology Clinic
 5915 Farrington Road, Suite 105
 Chapel Hill, NC 27517
 Phone: 984-974-7024 Fax: 984-974-7394

HEPATOLOGY FibroScan Referral FORM

Date: _____

PATIENT INFORMATION

UNC MR# (if known): _____

LAST NAME:	FIRST NAME:	MIDDLE NAME:	
Primary phone:	Alternate phone:	Gender: F <input type="checkbox"/> M <input type="checkbox"/>	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:		
Practice Name:		
Street Address:		City, State, Zip
PHONE:	FAX:	EMAIL ADDRESS:

INSURANCE INFORMATION

POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		LAST NAME:	FIRST NAME:
SEX: F <input type="checkbox"/> M <input type="checkbox"/>	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.

FOR OFFICE USE
 Calls made to schedule
 appointment:

Date	Result