Fibroscan request form

Cromwell Hospital

To book: Appointments team: 020 7460 5700 or CNS: 020 7460 2000 (extension 7200)
Email: Oscar.Martin-Simon@Cromwellhospital.com

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL

All sections of this form must be completed in full

PREPARATION: FASTING FOR 3 HOURS

Charge code: 377014

Referring Consultant: .....

Phone: .....

Email: .....

Patients Details (or sticker):

Name: .....

DOB: .....

MRN: .....

Clinical Indications (tick as appropriate):

Abnormal Liver Function Test ☐
ALD (Alcohol Liver Disease) ☐
Autoimmune Hepatitis ☐
Chronic Hepatitis B ☐
Chronic Hepatitis C ☐
Drug induced liver injury ☐
Haemocromatosis ☐
Liver disease unspecified ☐
NAFLD (Non-alcoholic Liver Disease) ☐
PBC (Primary Biliary Cholangitis) ☐
Other (please specify) ☐

Other information:

Blood Test Results:

AST: ALT:

Referring Clinician Signature

Signature: ..... Date / /

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