Indiana University Health

DIGESTIVE AND LIVER DISEASE CLINIC

Fibroscan Referral Form

PATIENT

Name Home Phone: Cell:

Address

IU MRN (If Available) SSN# DOB

Alternative Contact/Relative Phone ( )

Patient Weight: Height: Latex Allergies Yes No

REFERRING PHYSICIAN

Name

Address City/ST Zip

Phone ( ) Fax: ( ) **(Report/Results will be sent to this number)**

Office Contact

To Be Completed By Physician

☐ **Procedure and Consult** ☐ **Procedure only**

Diagnosis ____

ICD 10 Code (Diagnosis code must be liver related) ____

Patient History and Reason for Fibroscan:

Signature of Ordering Physician ________________________________ **Date** ________________

Please fax referral form and order to **317-948-9939 Attention: Fibroscan**

- **At least 3 hours of fasting is recommended prior to undergoing Fibroscan**

(Fibroscan is not recommended in individuals with pacemakers, pregnancy, ascites and prior liver resection)

Address: IU Health Digestive and Liver Disease Clinic, 550 N. University Blvd., Suite 1710, Indianapolis, IN 46202
For ongoing liver-related clinical trials at IU http://medicine.iupui.edu/GAST/research/LiverResearch