



LIVERSCAN REFERRAL

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www.mvscentre.com.au

Patient Details

Affix patient label below

Name: _____

DOB: _____

Phone: _____

Email: _____

Clinical notes and current medications

Referring Practitioner Details

Name: _____

Provider No: _____

Stamp/Signature:

Date: _____

Please fast for 4 hours prior to your procedure.

Clinical Details

- | | | |
|--------------------------------------|--|---|
| ☐ Alcohol | ☐ HIV | ☐ Thalassaemia |
| ☐ Hepatitis C | ☐ Iron Overload | ☐ Type I or II DM |
| ☐ Fatty Liver | ☐ Cystic Fibrosis | ☐ Methotrexate use |
| ☐ Obesity | ☐ Haemophilia | ☐ Cirrhosis on imaging |
| ☐ Diarrhoea | ☐ NASH/NAFLD | |
| ☐ Other _____ | | |

Refer to:

All Liverscan results will be sent to the referring practitioner.

Results include fibrosis and steatosis scores. Please note, a valid score requires a minimum of 10 scans and an IQR of $\leq 30\%$.

Please email reception@mvscentre.com.au if you require any further information relating to Liverscan or interpretation.

Date Booked:

Time Booked:
