ECCQ Fibroscan® Referral
(for Migrants and Refugees only)

Referring Doctor Details:

Dr Name:	Practice Name:	
Practice Address:	Phone number: Fax: Email:	Is your practice able to provide a room for FibroScan® to be performed in-house? Yes: ☐ No: ☐
Doctor Signature:		Date of Referral: / /

Patient Details:

Family Name:	Given Name: Preferred Name:	Date of Birth: / /
Sex: Male: ☐ Female: ☐	Post Code:	Phone:
Language Spoken at Home: Interpreter Required: Yes: ☐ No: ☐	Country of Birth:	Height: cm Weight: kg
Aetiology of Liver Disease: Hepatitis B: ☐ Hepatitis C: ☐	Pacemaker: Yes: ☐ No: ☐ ICD: Yes: ☐ No: ☐ Pregnant: Yes: ☐ No: ☐ Ascites: Yes: ☐ No: ☐ <18 years Yes: ☐ No: ☐	**If you have answered yes to any of these questions, a FibroScan® cannot be performed.**

Reason for Referral:

- **Baseline assessment of fibrosis:** ☐
- **Re-Assess level of fibrosis (2-3 yearly)** ☐
- **Pre-Treatment Assessment:** ☐
- **Other (please specify):**

Recent Blood test results <1 month if available
ALT: U/L (<200 U/L. FibroScan® contra-indicated if > 200)

Is you patient currently receiving regular monitoring?	Yes: ☐ No: ☐
Is this patient currently receiving treatment for their liver disease?	Yes: ☐ No: ☐

Please email this completed form to: referrals@eccq.com.au
Or fax to: (07) 3846 4453

Office Use only.	
Date Referral received:	Appropriate referral: Yes: ☐ No: ☐
Appointment date:	
Location FibroScan® to be performed at:	
Name of BCHW to attend:	or Interpreter Booked: Name: Time:

Ethnic Communities Council of Queensland