LIVER WELLNESS - FIBROSCAN REFERRAL FORM

PATIENT DETAILS:

Surname: _____ First Name: _____

Address: _____

Mobile No: _____ Home No: _____

Email address: _____ Date of Birth: _____

REFERRING CONSULTANT/GP:

Name: _____

Address: _____

Contact No: _____

Email address: _____

CLINICAL REASON FOR VISIT (tick as appropriate)

Abnormal liver blood tests	☐	Diabetes	☐
High cholesterol	☐	Routine health Check	☐
High BMI	☐	Other	☐

PAST MEDICAL HISTORY (ATTACH SUMMARY IF NECESSARY):

CURRENT MEDICATION:

Signed: _____ Date: _____

PLEASE FAX OR EMAIL BOOKING FORMS TO:
Liver Wellness
Suite 22 Beacon Consultants Clinic, Beacon Hospital, Sandyford, Dublin 18 | Suite 25 Blackrock Clinic, Blackrock, Co Dublin
Tel: 01-910 8901 Fax: 01 969-5572
Email: info@liverwellness.ie Web: www.liverwellness.ie