Liver Care
CANADA

CONSULTATION REQUEST FORM

Health Care Providers or Self Referrals please fax to 1-844-663-9012

PATIENT INFORMATION

Patient Name: _____

Date Of Birth: _____ (M/D/Y) HCN #: _____ VC: _____

Address: _____

Phone #: _____ Permission to leave voicemail for patient: Yes ❑ No ❑

PHYSICIAN INFORMATION

Physician Name: _____ Billing #: _____

Office Phone: _____ Office Fax: _____

Address: _____ Office Stamp:

_____

LIVER CARE CANADA LOCATION

❑ Barrie	❑ Kingston	❑ Northwest	❑ Scarborough	❑ York Region
❑ Durham Region	❑ London	❑ Ottawa	❑ Windsor	❑ Other:
❑ Hamilton	❑ Niagara	❑ Owen Sound	❑ Woodbridge	_____

REASON FOR REFERRAL

❑ Consultation

❑ Fibroscan

❑ Both

MEDICAL INFORMATION

❑ Hepatitis B

❑ Hepatitis C

❑ Fatty Liver Disease

❑ Rule In / Out Cirrhosis

❑ Medication Risk (Methotrexate)

❑ PBC / PSC / AIH

❑ Abnormal Liver Function Tests

❑ Liver Mass

❑ Other: _____

FOR CONSULTATIONS, PLEASE ATTACH ALL RELEVANT MEDICAL HISTORY, MEDICATION LIST, AND LAB / IMAGING REPORTS

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