Referral to □ ***A/Prof Miriam Levy +/or □ Dr Scott Davison***

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| --- | --- |
| Patient name: |  |
| Gender:  | Language spoken |
| DOB: | Phone:  |

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| **Clinical details:** |

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**HBsAg +ve** **Anti-HCV +ve** **ETOH excess** **Fatty liver** **Abnormal LFTs**  |
|  | **Please provide copy of FBC, INR and LFTs and imaging results if possible**  |

|  |  |
| --- | --- |
| Referring Doctor: |  |
| Provider Number: |  |
| Clinic address: |  |
| Date: |  |
| Signature:  |  |

**Please e-mail this form to:** SWSLHD-LiverpoolGastro@health.nsw.gov.au