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

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Clinical details:** | |  | | --- | |  | |  | |  | |  | |  |   **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