CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, ON N1R 3G2
519-621-2330 ext. 3505

Liver Clinic Referral Form

Complete and Fax Plus Test reports to:

519-629-3801

E-referrals accepted via OCEANS (preferred)

Last, First

Gender: M F O DOB: DD MM YYYY

Apt Address

City Prov. Postal Code

H: C:

Health Card #: (or IFH or UHIP) VC PROV

First available (Dr. O. Sarfaraz, Dr. A. Nguyen, Dr. S. Aziz, Dr. O. Akman)
** We reserve the right to book with the above health care professionals based on availability or patient's medical requirements.

REFERRALS WITHOUT UPDATED BLOODWORK AND ULTRASOUND ATTACHED WILL BE DECLINED.
Include and attach Fibroscan if available. Please Complete form to its entirety.

****Refer viral hepatitis directly to 745 Coronation Blvd. GI/Hepatology Cambridge community office (519-740-8440)**
****Refer undifferentiated liver lesions directly to Dr. Leung/HBP Kitchener community office (519-570-2865)**

- Please fax once only – if checking status of referral please call 519-621-2333 ext 2760.
- All referrals are assessed and triaged by Hepatology for medical urgency.
- The Liver Health Clinic will call patients with appointment times.

Reason for Hepatology Consultation

Non-Urgent	Semi-Urgent	Urgent
❑ *MASLD/MASH (Cambridge only) ❑ Autoimmune/PBC/PSC ❑ Hemangioma/FNH ❑ Polycystic liver disease ❑ Other _____ _____	❑ New cirrhosis ❑ Elevated liver enzymes greater than 5 ULN ❑ Other_____ _____	❑ Acute icteric/severe hepatitis ❑ Decompensated cirrhosis: (including needing paracentesis) ❑ Suspected malignant PRIMARY LIVER MASS ❑ Other_____ _____

***Patients not residing within CMH catchment area should be referred to a local gastroenterologist to be investigated initially for MASLD or mildly elevated liver enzymes (less than 5X ULN).**

Included in fax: ❑ CT ❑ Ultrasound ❑ Fibroscan ❑ MRI ❑ Meds ❑ Labs ❑ PMH ❑ EMR

Accessibility/Assistance: ❑ Mobility ❑ Translator

Additional Clinical Information: (please add additional pages and reports if required)_____

_____

_____

_____

STAFF Referring Physician

_____ _____ _____
Print Clearly Signature Date

_____ _____
License # or CPSO/CNO # OHIP Provider

❑ ER ❑ CB MED ❑ Primary Care ❑ Oncology ❑ GP ❑ GI ❑ Other Spec.: _____ ****Contact Information REQUIRED****

Address:_____
Suite # Street

_____/____/_____
City Prov Postal Code

PH: _____ FAX:_____
Required **Required**

OR OFFICE STAMP HERE:

_____
Family Doctor – if different than referring – PRINT CLEARLY

Provision of requested information ensures your patient is booked as appropriate to their medical condition