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

# Liver Clinic Referral Form

Telephone: 519-621-2333, ext. 4959

Fax Number: 519-629-3801

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

❑ Dr. Sarfaraz ❑ Dr. Aziz

❑ Dr. Nguyen ❑ Dr. Leung - HBP, Surgery for Liver Lesions

❑ Other:_____

** We reserve the right to assign staff based on availability or patient's medical requirements.

**COMPLETE & FAX PLUS TEST REPORTS TO: 519-629-3801**

(not to physician offices)

- Please fax once only – if checking, please call
- All referrals triaged by Hepatology for medical urgency
- Clinic will call patient with appointment time

STAFF Referring Physician

Print Clearly | Signature | Date

License # or CPSO/CNO # | OHIP Provider

****If known viral hepatitis refer to Dr. Sarfaraz/Nguyen in the community office**

❑ 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

Reason for Hepatology Consultation

❑ Elevated Liver Enzymes ❑ Cirrhosis a) compensated b) decompensated

❑ Liver Lesion

❑ Other - specify:_____

_____

_____

Include in fax: ❑ CT ❑ Ultrasound ❑ MRI ❑ Meds ❑ Labs ❑ PMH ❑ EMR

**Accessibility/Assistance**: ❑ Mobility ❑ Translator

All referrals are assessed by a staff hepatologist.
Provision of requested information ensures your patient is booked
as appropriate to their medical condition
**Additional Clinical Information:** (please add additional pages and reports if required)