A2C Liver Health Program Enrolment Form

Patient Information

Patient Name (First, Last):		Sex: ☐ Male ☐ Female Other	
Patient Address:		Province:	Postal Code:
Date of Birth (mm/dd/yyyy):		Healthcard Number:	
Home Phone:	Permission to leave voicemail ☐	Cell Phone:	Permission to leave voicemail ☐
Email:			
Alternate Contact:		Legal Guardian:	
Provider's Name:			
Provider's Address:			
Additional Information:			

Services Requested

- ☐ Chronic Disease Management
- ☐ Adherence support
- ☐ HE
- ☐ Diet and Lifestyle Education
- ☐ Disease or Symptom Education
- ☐ Other: _____

☐ Fibroscan – Sudbury Patients $60.00

- ☐ I acknowledge that the patient will be charged a fee for the Fibroscan and that the patient is aware there will be a cost for the scan.
- ☐ I request a compassionate scan for this patient. Reason: _____

Medical Information

Reason for Referral **(required):**	☐ NASH/NAFLD ☐ AIH ☐ PBC ☐ PSC	☐ HBV ☐ HCV ☐ Other, please list: _____	☐ Elevated Liver Enzymes NYD
For Follow-up Scan Only:	☐ Follow-up scan request ☐ Interval or date _____		
Special Considerations*:	☐ Type II Diabetes ☐ Sleep Apnea ☐ CAD	☐ Pacemaker	☐ Other (explain):

*Please note: Pregnancy, pacemakers, and implantable defibrillators are considered contraindications for Fibroscan

I, the treating Healthcare Provider (HCP), acknowledge by signing below that I have obtained verbal consent from the patient to share their contact and personal health information with the A2C Liver Health Program for the purposes of enrolment and the provision of the services requested above.

HCP Name: _____ Date: _____

HCP Signature: _____

Please fax completed forms to 1-833-932-1824

Email: A2Cliverhealth@supportprogram.com/ Phone: 1-833-932-1823 / Fax: 1-833-932-1824