

### PATIENT INFORMATION

Please bring your requisition and healthcare card to your appointment

Name \_\_\_\_\_ PHN \_\_\_\_\_  M  F  
 DOB \_\_\_\_\_ Insurance/WCB # \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_

PATIENT LABEL

### APPOINTMENT

Date \_\_\_\_\_  
 Time \_\_\_\_\_

### CLINICAL HISTORY



### LOCATIONS

Scan QR Code for directions and clinic specific information

- Saskatoon Lawson Heights**  
 75 Lenore Dr, Saskatoon SK S7K 7Y1  
 P: 306-933-4554 F: 306-933-4553  
 Mon - Fri 8:00 am - 4:00 pm

### ULTRASOUND

**M.A.S.L.D** (*Metabolic dysfunction-associated steatotic liver disease*) with SWE

Height (cm) \_\_\_\_\_ Weight (kg) \_\_\_\_\_ BMI \_\_\_\_\_ Diabetes  Yes  No **FIB-4** \_\_\_\_\_  
*(Lab Values Within Last Year)*

Albumin \_\_\_\_\_ Platelets \_\_\_\_\_ ALT \_\_\_\_\_ AST\* \_\_\_\_\_ HBA1C \_\_\_\_\_  
*\* Recommended but not required*

**H.C.C** (*Hepatocellular Carcinoma*) Surveillance \* repeated at 6 month intervals

**Ethnicity:**  Asian  Caucasian  African Descent  Other  Hep B (*male > age 40 and female > age 50*)

**Cirrhosis:**  Yes  Biopsy dx  Clinical Diagnosis  Fibroscan Score \_\_\_\_\_  Other \_\_\_\_\_

Cause of Cirrhosis: (*Check all that apply*)

Hep B  Hep C  ETOH  PBC  PSC  MASLD  Alpha 1 Anti-trypsin deficiency  Hemachromatosis  
 Wilson's Disease  AIH (auto immune)  Other \_\_\_\_\_

**Other Chronic Liver Disease**

Indication: \_\_\_\_\_

**Hepatic Dopplers**

### Technologist Notes

**EXAM PREPERATION** **Abdomen:** Nothing to eat or drink 6 hrs prior to exam.

**Previous on PACS**  Y  N

Location

### PRACTITIONERS INFORMATION

Practitioners Name \_\_\_\_\_  Stat Phone Report  
 Signature \_\_\_\_\_ P: \_\_\_\_\_  
 Phone/Fax \_\_\_\_\_  Stat Fax Report  
 Copy To \_\_\_\_\_ F: \_\_\_\_\_  
 Send Patient with Images (CD Copy)

### PRACTITIONERS STAMP/ID

