PHONE: (513) 584-9999
FAX: (513) 584-4959

LIVER TRANSPLANTATION REFERRAL FORM

TYPE OF REFERRAL: _______ LIVER TRANSPLANT _______ HEPATOBILIARY _______ HEPATOLOGY

PATIENT INFORMATION

LAST NAME ______________________ FIRST NAME ______________________ MI ______

DOB ____________ AGE ____________ SEX ____________ RACE ____________

ADDRESS ______________________ CITY ______________________ STATE ____________ ZIP ____________

HOME NUMBER ______________________ WORK NUMBER ______________________ SS# ______________________

PRIMARY DIAGNOSIS OF LIVER DISEASE ______________________________

REFERRING PHYSICIAN INFORMATION

NAME ______________________________ FACILITY ______________________________

ADDRESS ____

PHONE ______________________ FAX ______________________

PRIMARY CARE PHYSICIAN INFORMATION

NAME ______________________________ FACILITY ______________________________

ADDRESS ____

PHONE ______________________ FAX ______________________________

MEDICAL INFORMATION REQUIRED

CAUSE OF LIVER FAILURE ____

RECENT TOTAL BILIRUBIN __________ RECENT CREATININE __________ RECENT INR___________

IS THE PATIENT ON HEMODIALYSIS ______________________ SCHEDULE ______________________

DOES THE PATIENT HAVE ACTIVE SUBSTANCE ABUSE? ____

DOES THE PATIENT HAVE CHOLANGIOCARCINOMA? ______________________ DOES THE PATIENT SMOKE OR HAVE A HISTORY OF SMOKING? __________

DOES THE PATIENT HAVE HEPATOCELLULAR CARCINOMA? ______________________ HAS THE PATIENT UNDERGONE HCV TREATMENT ______________________

IN YOUR OPINION, DOES THE PATIENT HAVE AN IMPAIRMENT THAT WILL REQUIRE WHEELCHAIR OR OTHER ASSISTANCE? ______________________________

IF THIS PATIENT WILL REQUIRE A LANGUAGE INTERPRETER, WHAT IS THE NATIVE LANGUAGE? ______________________________

HAS THE PATIENT HAD A RECENT LIVER BIOPSY? ______________________________

Insurance Information

Primary Insurance ______________________ ID# ______________ Group # ________________

Medicare Supplement ______

Insurance Phone ( ) ______________________

Primary card holder name ______________________________ DOB ________________

Employer ______________________________ Relationship to patient ________________

Secondary Insurance Information

Secondary Insurance ______________________ ID# ______________ Group # ________________

Medicare Supplement ______

Primary card holder name ______________________________ DOB ________________

Employer ______________________________ Relationship to patient ________________

Please Return Referral Form with Copies/CD of:

- ○ Patient's insurance card
- ○ Recent H&P or letter from MD with clinical summary
- ○ Recent lab data and clinic notes
- ○ Recent hospitalization records
- ○ Liver biopsy, radiology, egd, colonoscopy reports
- ○ Most recent CD of imaging studies (CT, MRI, US, ERCP)