University Health

ADULT LIVER REFERRAL FORM

PLEASE FILL OUT THE INFORMATION BELOW:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____
(Street)

_____
(City/State/Zip)

Home Phone: _____

Cell Phone: _____

Work Phone: _____

❑ Male ❑ Female

Language ❑ English ❑ Spanish ❑ Other: _____

Marital Status: _____

Primary Insurance: _____

Medicare (if applicable): _____

Referring Physician Information

Name: _____

Specialty: _____

Address: _____
(Street)

_____
(City/State/Zip)

Phone: _____ Fax: _____

Office Contact: _____

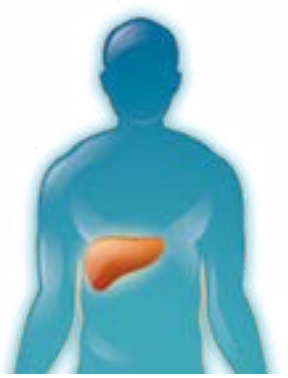
Additional Information:

_____

_____

_____

_____



Date of Referral:

Month	Day	Year

❑ Liver Transplant Consult ❑ Liver Disease Consult

❑ Liver/Pancreas Surgery

Patient Information

Liver Disease: _____

If patient is ETOH/IVDA, how long have they been abstinent? _____

Height: _____ Weight: _____

Please fax the following information with this form:

- ❑ Patient's demographic form
- ❑ Copy of insurance cards (front & back)
- ❑ Recent History and Physical
- ❑ Most recent labs (preferably within 1 month)
- ❑ MRI/CT/SONO/MRCP/ERCP of abdomen/liver
- ❑ Pathology reports
- ❑ Last two office visits
- ❑ Immunizations

Contact Information:

Referral Hotline
210-567-1617 or
888-336-9633

Referral Fax
210-702-4146 or
210-358-8529

Referral Address
University Transplant Center
4502 Medical Dr., MS 18, San Antonio, TX 78229

UniversityTransplantCenter.com/referral