

**Liver Transplantation Referral Form**

Date: \_\_\_\_\_

UTSW MRN: \_\_\_\_\_

**Referring Provider Information**

**Referring Physician**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

**Primary Care Physician**

same as Referring

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Please attach copy of insurance card.

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**Reason for Referral**

- Liver Transplantation Referral
- General Hepatology Referral
- Hepatobiliary Referral
- Liver Tumor Referral
- Other: \_\_\_\_\_

What is your preferred UT Southwestern location?

- Dallas  Fort Worth  Austin  El Paso

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Weight: \_\_\_\_\_ lbs.

Labs: Date \_\_\_\_\_

INR: \_\_\_\_\_ Total Bilirubin: \_\_\_\_\_

Creatinine: \_\_\_\_\_ Albumin: \_\_\_\_\_

MELD Score: \_\_\_\_\_

**Reason for Referral**

- Hepatitis C  Hepatitis B  Autoimmune
- Alcohol  Hepatocellular Carcinoma (HCC)
- Hemochromatosis  NASH/NAFLD
- Primary Biliary Cirrhosis (PBC)
- Primary Sclerosing Cholangitis (PSC)
- Wilson's Disease  Increased LFTs
- Liver Mass  Cholangiocarcinoma (CCA)
- Ascites  Varices  Portal Hypertension
- Hepatic Encephalopathy
- Other \_\_\_\_\_

Question to be addressed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please Fax Application and Medical Records to:  
 214-645-1903**

**For Questions or Assistance: Please call our  
 Intake Coordinator at 877-392-1528 or our  
 Transplant Clinic at 214-645-1919 Option 5**