UT Southwestern
Medical Center

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 ☐ Lubbock
☐ El Paso ☐ Plano
☐ Fort Worth

Height: _____ ft. _____ in.
Weight: _____ lbs.

Labs: Date _____

INR: _____ Total Bilirubin: _____

Creatinine: _____ Sodium: _____

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: 214-645-1901

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