Charles O. Strickler Transplant Center
Liver Transplant Referral Form

Fax to: Amy Gardner **Fax #: 434-924-8774**

(Please Print)

❑ **Liver Only** ❑ **Liver and Kidney** ❑ **Consult Only** ❑ **Other Eval/Procedure** ___________________________________
❑ On Dialysis

Today's date:	Name of Practice:	
Address:	Phone: ( )	Fax: ( )
Referring Provider:	**Contact Person:**	

PATIENT INFORMATION						
Patient's last name:	First:	Middle:	Sex ❑ M ❑ F	Birth Date / /	Soc. Security Number __ __ __ - __ __ - __ __ __ __	
Street address:			PO Box:		Home phone: ( )	
City:	State:	ZIP Code:	Work phone: ( )		Cell phone: ( )	
Name Additional Contact:	Relation to Patient:		Primary phone: ( )		Cell phone: ( )	

INSURANCE INFORMATION				
(Please Include Copy of Insurance Card)				
Is this patient covered by insurance?	❑ Yes	❑ No		
Please indicate primary Insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:

LIVER DIAGNOSIS INFORMATION

(Please Check All That Apply)

❑ Cryptogenic ❑ Hemochromatosis ❑ HCV ❑ HBV ❑ ETOH ❑ PBC ❑ PSC ❑ A1A ❑ HCC

❑ Alagille's Syndrome ❑ Other ____

PLEASE INCLUDE THE FOLLOWING AVAILABLE RECORDS

			Most Recent Lab Results
❑ 3 Months Clinic Notes	❑ Colonoscopy	❑ Abdominal Images	❑ Chemistries
❑ Consultant Notes	❑ Cardiac Stress	❑ Ht. & Wt.	❑ Hematology
❑ CXR Results	❑ Cardiac Cath	❑ Last ETOH	❑ ABO
❑ TB Test Results	❑ Echo	❑ Counseling	❑ Urine Studies
❑ All Path Reports	❑ EKG	❑ Mammogram (female)	❑ PSA (males)
❑ Immunizations	❑ EGD	❑ Pap Smear (female)	

PO Box 800265, Charlottesville, VA 22908 **Phone: 434-924-8604 (opt 3, 2) or 1-800-543-8814**