UVA Children's

Charles O. Strickler Transplant Center
Pediatric Liver Transplant Referral Form

Fax to: TXP Referral Coordinator **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:**	
PCP (if different from referring):			

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 of Parent/Guardian:	Relation to Patient:		Primary phone: ( )		Cell phone: ( )
Preferred Language: Interpreter Needed: ❑ Y ❑ N					Marital Status:

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 ❑ Hepatoblastoma ❑ Metabolic disorder (MSUD/Urea Cycle) ❑ AIH ❑ Biliary Atresia ❑ CF

❑ Acute/fulminant liver disease ❑ Alagille's ❑ Other _____

PLEASE INCLUDE THE FOLLOWING AVAILABLE RECORDS

❑ 3 Months Clinic Notes ❑ Consultant Notes ❑ CXR Results ❑ US results ❑ Imaging results ❑ All Path Reports	❑ Echo ❑ EKG ❑ EGD ❑Previous surgical reports	❑ Ht. & Wt. ❑ Counseling ❑ Immunizations/vaccination history ❑ TB Test Results	**Most Recent Lab Results** ❑ Chemistries ❑ Hematology ❑ ABO/Blood Type ❑ Urine Studies

PO Box 800265, Charlottesville, VA 22908 **Phone: 434-924-8604 or 1-800-543-8814**