

METHODIST UNIVERSITY HOSPITAL TRANSPLANT INSTITUTE

Center for Advanced Liver Disease/Liver Transplant Referral Form

This form must be filled out in its entirety.

Mail or Fax the form as follows:

Methodist University Hospital Transplant Institute

1265 Union Avenue, 1 Sherard, Suite 184 • Memphis, TN 38104

Phone: 901.516.7125 • Fax: 901.516.2971

In addition to completion of this referral form, the following information is REQUIRED:

- ☐ Copy of Insurance Card **AND** Prescription Drug Cards (FRONT and BACK)
- ☐ List of Medications
- ☐ Recent H & P, Office notes, Hepatology panel and other recent labs, pertinent radiologic studies including biopsy reports and ultrasound tests INR, creatinine, bilirubin, and other diagnostic studies.

Referral Date: _____

Referring Physician & Phone Number: _____

Patient Name: _____

Patient Address: _____

Phone Number: (____) _____ Date of Birth: _____

Social Security Number: _____

Diagnosis w/MELD Score (if possible): _____

Cirrhosis: ☐ Yes ☐ No

Interpretive Service Needs: ☐ Yes ☐ No Please explain: _____

Primary Care Physician & Phone Number: _____

Insurance: _____

Completed by: _____

Completion of this form constitutes a referral for transplant evaluation. Signing this form indicates that liver transplantation at Methodist University Hospital Transplant Institute is medically necessary. All information required must be forwarded for referral to be accepted. Missing information may cause a delay in the evaluation process.

Independent Practitioner Signature: _____ Date: _____

