JOHN C. MCDONALD
REGIONAL TRANSPLANT CENTER

Liver Referral Form

Liver Transplant Coordinator 318-212-4275

Send completed form with: ☐ recent history and physical ☐ social history ☐ lab ☐ CT scan ☐ EGD ☐ Colonoscopy ☐ ultrasound ☐ liver biopsy ☐ insurance cards

Please FAX information to: 318-212-4957 Attention: Christie

Patient Information	Last Name:	First Name:	MI:	DOB:
Address:	Apt#:	City:	State:	Zip:
Home Phone:	Alternate Phone:	SSN:		
Sex: ☐ Male ☐ Female ☐ Other	Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other:			
Speaks English: ☐ Yes ☐ No Language Preferred:	Hearing impaired: ☐ Yes ☐ No Vision impaired: ☐ Yes ☐ No			
Referring Physician:	Phone:	Fax:		
Address:	City:	State:	Zip:	

Insurance Information			
Insurance	**Contract Number**	**Group Number**	**Phone Number**

******(Please fax a copy of the patient's current insurance cards)******

Medical Information	Blood Transfusions: ☐ Yes ☐ No	Abdominal Surgeries ☐ Yes ☐ No
Height :_____ Weight:_____	Allergies:	
Cause of liver failure:	Limitations ☐ walker ☐ wheelchair ☐ cane other_____	
Hepatitis A: ☐ Negative ☐ Positive Hepatitis B antigen: ☐ Negative ☐ Positive	Hepatitis C: ☐ Negative ☐ Positive HIV: ☐ Negative ☐ Positive	
INR: T.Bili:	Creat: Na:	MELD SCORE:

IF ANSWERING YES TO ANY QUESTION BELOW PLEASE PROVIDE COMMENTS		
History or current cancer	☐ Yes ☐ No	Comments:
Active infections	☐ Yes ☐ No	Comments:
Psychological/social limitations	☐ Yes ☐ No	Comments:
CAD, PVD, or CVA disease	☐ Yes ☐ No	Comments:
Compliance	☐ Yes ☐ No	Comments:
Peptic ulcer disease	☐ Yes ☐ No	Comments:
History or current substance abuse	☐ Yes ☐ No	Comments:

Completed by: _____ Date: _____

Revised 6/09, 10/10, 3/14, 10/15, 6/19