UPMC LIVER CARE

Referral Form



PATIENT INFORMATION:				
Patient Name:			Date of Birth:	
(Last Name)	(First Name)			
Patient Gender: Male Fema				
Home Address:				
Best Contact Phone Number:				
REFERRING PHYSICIAN IN	IFORMATION:			
Referring Physician Name/Group:_		Referring Physician Credentials:	MD PA NP Other:	
Office Contact:				
Referring Physician Address:				
		Date of Referral:		
Liver/Hepatology Referral		Liver Transplant Evaluation		
Reason for Referral (choose all that apply):		Patients who are actively drinking, or recently stopped drinking (within past 3 months), and/or are over 70 years old, should be referred for		
Alcohol liver disease	Primary biliary cholangitis (PBC)	Hepatology Consult (left column) rather than Liver Transplant Evaluation.		
MASLD/MASH (aka, NAFLD/NASH/	Primary sclerosing	Medical History/Indications/Complications (past or present): Diagnosis:		
fatty liver/hepatic steatosis)	cholangitis (PSC)			
Hepatitis C	Liver mass/liver lesion	Presence of advanced liver of		
Hepatitis B	Pregnancy-related liver	Any evidence of decompensation regardless of MELD score		
Elevated liver enzymes	disorder	Encephalopathy	Gastrointestinal bleeding (GIB	
Autoimmune hepatitis	Complex congenital heart disease (Fontan)	Ascites	Thrombocytopenia	
Other reason for referral and/or additional comments:		Spontaneous bacterial peritonitis (SBP)	Portal hypertension Dialysis	
		Varices	Dialysis	
Does the patient have a diagnosis of primary liver cancer (hepatocellular carcinoma or cholangiocarcinoma)? yes no		Splenomegaly		
Does the patient have cirrhosis?		Alcohol Use History:		
·	•	Last Drink:		
Are the clinical records for this referral available in Epic or Care Everywhere? yes no		Illicit Drug History:		
If not available in Epic or Care Everywhere,		MELD Score (if known):		
please fax the following information to our office:		Has patient previously had a tra	nsplant? yes no	
 Relevant (within 6 months) clinic notes and/or hospital discharge summaries 	Recent (within 12 months) abdominal imaging reports (CT, MRI, abdominal ultrasounds)	Is patient on transplant waitlist a	at another center? yes no	
		Please fax the following information to our office:		
		Copy of insurance cards	 EGD, colonoscopy, 	
• Recent (within 6 months)		History and physical PAP, mammogram, PAP, mammogram,		
lab data, including liver enzymes and any other		Radiology imaging	PFT, DEXA, Liver BX, PET CT (if available)	
liver-related testing		Recent labs/liver panel	Any other pertinent	

Please fax this completed referral and clinical records to our UPMC Center for Liver Care Office: Fax: 412-605-1064 | Phone: 412-647-1170

Please fax this completed referral and clinical records to UPMC Transplant Services:
Fax: 412-647-2449 | Phone: 412-647-3300

information

Radiology testing

(MRI, CT, US)