UPMC LIVER CARE

Referral Form

PATIENT INFORMATION:

Patient Name: ______________________________ (Last Name) (First Name) (Middle Name) Date of Birth: ____________

Patient Gender: ____________ Social Security #: ____________

Home Address: ____________

Best Contact Phone Number: ____________

REFERRING PHYSICIAN INFORMATION:

Referring Physician Name/Group: ____________ Referring Physician Credentials: MD PA NP Other: ______

Office Contact: ____________

Referring Physician Address: ____________

Phone #: ____________ Fax #: ____________ Date of Referral: ____________

Liver/Hepatology Referral

Reason for Referral **(choose all that apply)**:

- Alcohol-associated liver disease
- MASLD/MASH (a.k.a. NAFLD/NASH/ fatty liver/hepatic steatosis)
- Hepatitis C
- Hepatitis B
- Elevated liver enzymes
- Autoimmune hepatitis
- Primary biliary cholangitis (PBC)
- Primary sclerosing cholangitis (PSC)
- Liver mass/liver lesion
- Pregnancy-related liver disorder
- Complex congenital heart disease (Fontan)

Other reason for referral and/or additional comments:

____

Does the patient have a diagnosis of primary liver cancer (hepatocellular carcinoma or cholangiocarcinoma)? yes no

Does the patient have cirrhosis? yes no unknown

Are the clinical records for this referral available in Epic or Care Everywhere? yes no

If not available in Epic or Care Everywhere, please fax the following information to our office:

- **Relevant (within 6 months) clinic notes and/or hospital discharge summaries**
- **Recent (within 6 months) lab data, including liver enzymes and any other liver-related testing**
- **Recent (within 12 months) abdominal imaging reports (CT, MRI, abdominal ultrasounds)**

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

Liver Transplant Evaluation

Patients who are actively drinking, or recently stopped drinking (within past 3 months), and/or are over 70 years old should be referred for Hepatology Consult (left column) rather than Liver Transplant Evaluation.

Medical History/Indications/Complications (past or present):

Diagnosis: ____________

- Presence of advanced liver cancer
- Any evidence of decompensation regardless of MELD score
- Encephalopathy
- Ascites
- Spontaneous bacterial peritonitis (SBP)
- Varices
- Splenomegaly
- Gastrointestinal bleeding (GIB)
- Thrombocytopenia
- Portal hypertension
- Dialysis

Alcohol Use History: ____________

Last Drink: ____________

Illicit Drug History: ____________

MELD Score (if known): ____________

Has patient previously had a transplant? yes no

Is patient on transplant waitlist at another center? yes no

Please fax the following information to our office:

- **Copy of insurance cards**
- **History and physical**
- **Radiology imaging**
- **Recent labs/liver panel**
- **Radiology testing (MRI, CT, US)**
- **EGD, colonoscopy, PAP, mammogram, PFT, DEXA, Liver BX, PET CT (if available)**
- **Any other pertinent information**

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

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