UPMC TRANSPLANT SERVICES
THOMAS E. STARZL TRANSPLANTATION INSTITUTE
3459 Fifth Ave, 7 South, Pittsburgh, PA 15213

Liver Transplant Evaluation Referral Form

PATIENT INFORMATION:

Last Name: _____

First Name: _____

Sex: _____ DOB: _____

Address:

Social Security # : _____

Home Phone: _____

Cell Phone: _____

Best Time to Contact: _____

REFERRING PHYSICIAN INFORMATION:

Referring Physician Name: _____

Address: _____

Phone: _____

Fax: _____

PRIMARY CARE PHYSICIAN:

Primary Care Physician Name: _____

Address: _____

Phone: _____

Fax: _____

INSURANCE INFORMATION:

Insurance: _____

ID Number: _____

Group Number: _____

Secondary Insurance: _____

ID Number: _____

Group Number: _____

Policy Holder: _____

MEDICAL HISTORY/INDICATIONS:

Diagnosis: _____

Indications:

☐ Meld score > 15 ☐ Any evidence of decompensation regardless of MELD score ☐ Presence of advanced cancer

Complications (past or present):

☐ Encephalopathy ☐ Varices ☐ Thrombocytopenia
☐ Ascites ☐ Splenomegaly ☐ Portal hypertension
☐ SBP ☐ GIB ☐ Dialysis

Smoking History: _____

ETOH History: _____

Last ETOH: _____

Illicit Drug History: _____

Last Use: _____

Meld Score (if known): _____

Does patient have a potential live donor? ☐ yes ☐ no

Has patient previously had a transplant? ☐ yes ☐ no

Is patient listed 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

After reviewing records, the intake team may determine that it is necessary for the patient to be 'pre-evaluated' by a transplant hepatologist visit.

CONTACT US:
PHONE: **412-647-3300** OR **1-844-UPMC-LIVER**
FAX: **412-647-2449**
EMAIL: **transplant@upmc.edu**