UPMC LIVER CARE

Referral Form

UPMC
LIFE CHANGING MEDICINE

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Name)

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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