JOHN C. MCDONALD
REGIONAL TRANSPLANT CENTER

Liver Referral Form

Liver Transplant Intake Coordinator 318-212-8140

Send completed form with: • recent history and physical • social history • lab • CT scan • EGD • colonoscopy • ultrasound • liver biopsy • insurance cards
Please FAX information to: 318-212-4503 • Attention: Amy Bunch

Last Name: _____ **First Name:** _____ **MI:** _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone :(_____)_____ **Alternative Phone :**(_____)_____

Referring Physician: _____ **Phone:** (____)_____ **Fax:** (____)_____

Insurance Information

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

Insurance	Contract Number	Group Number	Phone Number

Medical Information

Cause of Liver Failure: _____ **Activity Limitations:** _____

Blood Transfusions: ☐ YES ☐ NO **Allergies:**_____

Abdominal Surgeries ☐ YES ☐ NO

Weight: _____ **Height:** _____

Hepatitis C: ☐ Negative ☐ Positive **Hepatitis B antigen:** ☐ Negative ☐ Positive

Hepatitis A: ☐ Negative ☐ Positive **HIV:** ☐ Negative ☐ Positive

INR:____ **T.Bili:**_____ **Creat:**_____ **Na:**_____ **MELD SCORE:**_____

History or current cancer: ☐ Yes ☐ No Comments:_____

Active infections: ☐ Yes ☐ No Comments:_____

Peptic ulcer disease: ☐ Yes ☐ No Comments:_____

CAD, PVD, or CVA disease: ☐ Yes ☐ No Comments:_____

History or current substance abuse: ☐ Yes ☐ No Comments:_____

Psychological/social limitations: ☐ Yes ☐ No Comments:_____

Compliance/other: ☐ Yes ☐ No Comments:_____

Completed by: _____ Date: _____

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