UCSF Medical Center

LIVER REFERRAL FORM

Check the type of UCSF referral requested and fax with records to designated fax number:

	UCSF DEPARTMENT	PHONE	FAX
☐	Liver Transplant Full Evaluation	415.353.1888	415.353.2102
☐	Hepatology Consult (non-transplant)	415.353.2318	415.353.2407
☐	Hepatitis C (HCV) Treatment Clinic	415.353.2318	415.353.2407
☐	Liver Surgery Consult (non-transplant)	415.353.1888	415.353.2102
☐	Liver/GI Oncology Consult / Dr. Kate Kelley (non-transplant)	415.353.9888	415.353.9931
☐	Hepatobiliary Disease Consult (non-transplant)	415.353.9888	415.502.2236

REFERRAL INFORMATION:

Referral Date: _______________

PATIENT INFORMATION/ DEMOGRAPHICS:

(Fill out the information below AND send an attached document that includes the same information.)

Name:	**DOB:**	**HT:**
RACE/ETHNICITY:	**BMI:**	**WT:**
LANGUAGE:	**INTERPRETER ? YES NO (Check one)**	**Male Female**

Address:	**PATIENT CONTACT INFORMATION**
	Home Phone:
	Work Phone:
	Cell Phone:
SSN# / HIC#:	**E-mail:**

EMERGENCY CONTACT:

PATIENT HEALTH INFORMATION

(Complete the information below and send medical records requested on the fax cover sheet)

Diagnosis/Cause of liver disease: **Diagnosis 1** **Diagnosis 2**	**Notes:**	Allergies:
Date of last alcohol use:	**MELD-Sodium Score (for transplant):** * Include date of MELD labs/values if available	

GI / REFER MD	PRIMARY CARE PRIVIDER
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Fax:**

INSURANCE: Please ensure to enclose a copy of both sides of the patient's insurance card.

Revised 2016 December