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**Liver Transplant Services Referral Worksheet**

*Please also complete Standard Referral Form*

**Referring Provider Information**

Physician Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

INR \_\_\_\_\_ Bilirubin \_\_\_\_\_ Creatinine \_\_\_\_\_

Diagnosis \_\_\_\_\_

**Does the patient have any of the following issues? (Please check all that apply)**

- Any use of alcohol within the past 6 months
- Any use of cocaine, heroin, marijuana or any illicit (street) drugs within the past 6 months.
- Any use of prescribed narcotics or benzodiazepines within the past 6 months.
- Currently using any tobacco products.
- Psychiatric diagnosis.
- History of coronary artery disease.
- History of significant renal disease.
- Other (please specify) \_\_\_\_\_

**Which of the following best describes this patient? (Please check one)**

- An optimal transplant candidate with no other medical, surgical or psychosocial issues.
- A good candidate, but with a medical, surgical or psychosocial concern.
- A possible candidate with multiple medical, surgical or psychosocial concerns.