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: _____

Does the patient have someone interested in donating a portion of their liver to them? (Check one) YES ☐ NO ☐

PATIENT INFORMATION/ DEMOGRAPHICS:

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

Do you have someone wh
donate to?

Name:

DOB:

LANGUAGE:

INTERPRETER ? (Check one) **YES** ☐ **NO** ☐

Male ☐ **Female** ☐

Address:

PATIENT CONTACT INFORMATION

Home Phone:

Work Phone:

Cell Phone:

SSN# / HIC#:

E-mail:

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

N/A

GI / REFERRING MD

Name:

Address:

Phone:

Fax:

PRIMARY CARE PROVIDER

Name:

Address:

Phone:

Fax:

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