

Liver Transplant Referral

- Hepatology**
- Hepatobiliary Surgery Dr. Earl/ Dr. Anderson**
- Dr. Shannon Orr**



Name: _____

Date of Referral: _____

Address: _____

SSN: _____

DOB: _____

Home/Cell Phone #: _____

Work Phone #: _____

Height: _____ Weight: _____

Race: _____

Emergency Contact: _____

Phone Number: _____

Diagnosis: _____

PPMH: _____

PPSH: _____

Social History: _____

Current Medications: **(please provide medication list)** _____

Allergies: _____

Referring MD: _____

Address: _____

Phone Number: _____

Fax #: _____

Primary Care MD: _____

Address: _____

Phone Number: _____ Fax#: _____

Insurance: _____

Member #: _____ Group# _____

Notes:

Please make sure you include each of these items below when sending a referral:

- **Copy of All Insurance Cards (Front and Back)**
- **History and Physical (must be within 1 year of referral date)**
- **Latest Lab results (must be within 1 year of referral date)**
- **Patient information fact sheet (demographic)**
- **Dental clearance letter**
- **Any previous cardiac testing (EKG, Stress Test, ECHO, Cath, Chest X-ray, etc). Pap smear and mammogram for women over the age of 40, unless strong family history**
- **Signed Release of Information form**

Please place all CT Scans, MRI, and other radiological films on CD and send to:

University of Mississippi Medical Center

ATTN:

University Transplant
 University of Mississippi Medical Center
 2500 North State St.
 Jackson, MS 39216
 Phone: 601-984-5065 • Fax 601-815-0328