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**

Revised: 5.24.2017