



940 NE 13th Street | Suite 2000 | Oklahoma City, OK 73104  
Phone (405) 271-7498 | Toll Free (877) 817-6911 or (888) 777-7081 | Fax (405) 271-4329

## Hepatitis C Referral

Are you referring this patient for a Liver Transplant Evaluation? ☐ YES ☐ NO

DATE:

This is a Non-English speaking patient: ☐ YES ☐ NO

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Race: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Previous Transplant: ☐ YES ☐ NO Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Interval History: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send the following information with the referral form: (if available)

☐ Demographics

☐ Labs (most recent) **(Including PCR and Genotype)**

☐ Insurance info (card front & back)

☐ Liver biopsies

☐ H & P

☐ Pathology reports

☐ Office/clinic/progress notes

☐ HCV antibody

☐ Operative reports

☐ Radiology & other diagnostic imaging **CD/DISKS**

☐ Discharge Summaries

☐ Ultrasounds

☐ Medication list

☐ EGD/Colonoscopy

☐ Hep B Immunization documentation

Other: \_\_\_\_\_

☐ Last Flu shot

Other: \_\_\_\_\_

☐ Last Pneumo Vax shot

Other: \_\_\_\_\_

REFERRING PHYSICIAN:

NPI: \_\_\_\_\_

Printed Name \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_