



- 1 University of Kentucky A.B. Chandler Hospital
- 1 UK HealthCare Good Samaritan Hospital
- 1 UK HealthCare Ambulatory Services
- 1 UK Dental and Oral Health Clinics

Clinic Location

- Lexington
- Louisville (in collaboration with Norton Healthcare)
- Northern Kentucky
- Bowling Green

University of Kentucky Transplant Center - LIVER TRANSPLANT AND HEPATOBILIARY SURGERY CONSULTATION FORM

To ensure your request is processed as quickly as possible, please fax this form, any supporting information and your cover sheet to **(859) 257-3644**. To speak with a representative directly, call toll-free (888) 808-3212 (select option 1 when prompted) or in Lexington (859) 323-8500 (select option 1 when prompted). We appreciate your referral and look forward to working with you and your patients.

Please provide the following items with this fax, all items are required for referral to be processed:

- | | |
|---|---|
| <input type="checkbox"/> Patient demographic sheet | <input type="checkbox"/> Most recent laboratory results, including creatinine, total bilirubin and INR |
| <input type="checkbox"/> Medication list | <input type="checkbox"/> Any previous cardiac testing (EKG, stress test, echo, cath) and chest x-ray |
| <input type="checkbox"/> Radiology testing (MRI, CT Scan, DUS) | <input type="checkbox"/> Copy of insurance cards (front and back) |
| <input type="checkbox"/> CD copy of images to be mailed | <input type="checkbox"/> Liver work-up labs (serologies, genotype, ferritin levels, etc.) |
| <input type="checkbox"/> EGD and colonoscopy | <input type="checkbox"/> Social work notes |
| <input type="checkbox"/> Recent history and physical and / or discharge summaries | |

Patient Information:		Name:	Date of Birth:	
<input type="checkbox"/> Liver Transplant / Liver Failure		<input type="checkbox"/> Surgical (Hepatobiliary and Liver Lesions)		
Mailing Address:				
City:	State:	Zip:	Phone:	
SSN:	Diagnosis:			
Secondary Contact (Name):			Secondary Contact (Phone):	
Maiden Name:		Mother's Maiden Name:		
Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Referring Physician Information:		Specialty:	NPI:	
Name:		Phone:	Fax:	
Street Address:				
City:	State:	Zip:	County:	
Email of Physician:			Contact Person:	

Primary Care Physician Information:		NPI:		
Name:		Phone:	Fax:	
Street Address:				
City:	State:	Zip:	County:	
Email of Physician:			Contact Person:	

This form can be found online at www.ukhealthcare.uky.edu/transplant/