Clinical Transplant Services
Liver Transplant Program
Mail Code: L590 ● 3181 SW Sam Jackson Park Rd. ● Portland, OR 97239 -3098
Tel: (503)494-8500 ● Toll free: 800/452-1369 x 8500 ● Fax: 503/494-5292

LIVER TRANSPLANT REFERRAL FORM

Fax Complete Referral to the Liver Transplant Program at: 503-494-5292

If your patient is scheduled for a liver transplant evaluation at OHSU, our program will do a thorough medical and psycho/social evaluation and make further recommendations. Patients who are felt to have substance abuse issues are often requested to complete a substance abuse assessment or participate in rehabilitation and develop long-term recovery support (AA, Smart Recovery, or religious-based long-term recovery support). To document abstinence, it is recommended to submit urine ethyl glucuronide screens and urine drug screens every 1-4 weeks depending on your assessment of the patient's risk of returning to substance abuse. If you and your patient feel that it is appropriate, beginning these things prior to undergoing a transplant evaluation often improves the likelihood and timeliness of getting the patient on the transplant list.

Please include the following:

- ☐ This referral form (completed)
- ☐ Recent Chart Notes regarding this illness (6 months back)
- ☐ Lab: Complete metabolic panel, CBC, and INR (Drawn within last 2 months)
- ☐ Current Medications List
- ☐ Any CTs and MRIs from the last 6 months. Fax reports and push images into OHSU PACS system or burn to disk. Dicom-Uncompressed formats only.
- ☐ Last EGD and colonscopy with pathology reports, if done.
- ☐ Screenings:
  - HIV Screen (within last 6 months)
  - Serum Alcohol
  - Urine Drug Screen with confirmation (opiates, cocaine, marijuana, barbiturates, and amphetamines)
  - Urine Ethyl Glucuronide
  - Urine Nicotine with metabolites.

Date: _____/_____/_____

Physician Information

Referring Provider: ____Email____________________

Address: ____

Phone: (____) _____-________ Fax: (____) _____-________

Primary Care Physician: ____________________________ Phone: (____) _____-________

Patient Information

Name (first, middle, last): ____

Address: ____

Home Phone: (____) _____-______ Cell Phone: (____) _____-________ Work Phone: (____) _____-______

Date of Birth: _____/_____/_____ Social Security Number: ________-_____-_________

Gender: ☐ Male ☐ Female Height: ______________☐ cm. ☐ in. Weight: _____________☐ kg ☐ lbs

English speaker ☐ yes ☐ no, other language: ______________________ (☐ Interpreter required)

Insurance Information

(1)Primary Insurance: _______________________________ ID#: __________________________

Subscriber: _____________________________________ Group #: _______________________

(2)Secondary Insurance: _______________________________ ID#: __________________________

Subscriber: _____________________________________ Group #: _________________________

Medicare Part D Plan (if Medicare insured): ☐ No ☐ Yes, _________________________________

ID: ________________ Group: ___________________ BIN: _______________ Phone#: ___________________

Medical History *(This information is required to assess your patient's appropriateness for evaluation)*

Diagnosis: ____

Date of onset of current illness: _____/_____/_____ Date of onset of similar illness: _____/_____/_____

Most Recent (within last 2 months) INR______ Alb______ T bili______ Creatinine______ Date Drawn____/_____/_____

Hep B Patients Only: Has the patient responded to therapy? (HBV <100,000 IU/ml?) ☐ yes ☐ no

HIV (Last 6 months) Date Drawn____/_____/_____ ☐ pos ☐ neg

Cardiac Risk Factors:

Angina/Coronary Artery Disease ☐ yes ☐ no If yes, stable? ☐ yes ☐ no

1st degree family member w/ heart disease <65 ☐ yes ☐ no

History of Diabetes ☐ yes ☐ no

Hypertension ☐ yes ☐ no

History of Smoking ☐ yes ☐ no If yes, abstinent: mo/yrs____________________

History of Malignancy ☐ yes ☐ no If yes, explanation: ________________________

(Exclude non-melanoma skin cancer)

Hepatocellular Carcinoma of the liver ☐ yes ☐ no

Ascites ☐ yes ☐ no

Spontaneous Bacterial Peritonitis ☐ yes ☐ no

History of Alcohol Use ☐ yes ☐ no If yes, Abstinent: mo/yrs____________________

(Must be abstinent for at least 6 months, with documented screens)

History of Drug Use ☐ yes ☐ no If yes, Abstinent: mo/yrs____________________

Is the patient allergic to Iodine? ☐ yes ☐ no
Does the pt have metal in eyes/aneurysm clip? ☐ yes ☐ no
Will patient accept blood products? ☐ yes ☐ no
(Must accept blood products to be considered for transplant)

Additional comments:
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