EMORY
TRANSPLANT CENTER

Liver Transplant Referral Guide

Referring Physician:________________________________ **GI Name**:______________________________

Practice Name:____________________________________ **GI Phone**:______________________________

Referring Address:_________________________________

Phone Number:____________________________________

Fax Number:______________________________________

Requested Documentation

Fax Documents to: 404-712-2769

Email Documents to:
liverreferral@emoryhealthcare.org

- ☐ Primary Insurance Cards: front & back copy
- ☐ Secondary Insurance Cards: front & back copy
- ☐ H&P (within 6 months) – if not available, provide hospital discharge summary, admission H&P or last office visit note.
- ☐ Recent Labs (within 3 months)

Patient Information

ICD 10 Diagnosis/Reason for Visit:________________________________

Patient (Last) Name:______________________________________

Patient (First) Name:__________________________________ **MI**:____

DOB:_______________ **Gender**: ________

Main Phone:__________________ **Secondary Phone**:_______________

Race:_______________ **Preferred Language**:_________________

Insurance Company:_______________________ **Policy Number**:_______________________

Insurance Subscriber:______________________ **Relationship to Pt**:_____________________

Medical Information

Patient on Dialysis: Yes / No

Completed by: _________________________ Phone:___________________________

Fax:____________________________

Thank you for your referral to the Emory Liver Transplant Program.
In order to expedite your patient's evaluation, please complete this form in its entirety.
Once we receive all necessary patient information, the patient will typically be seen within 7 days. We will notify the patient regarding appointment date/time, test results, treatment, & diagnostic information. We will also provide visit notes to your office using the contact information provided above.

EMORY
TRANSPLANT CENTER