PRINT BLANK FORM | PRINT COMPLETED FORM AND RESET | RESET FORM

MUSC Health
TRANSPLANT CENTER

ASCREENCRIT

Referral for Liver Transplantation

Form Origination Date: 7/13
Version: 1 Version Date: 7/13

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Complete and return to: MUSC Transplant Program
162 Ashley Avenue, MSC 586
Charleston, SC 29425
Fax: 843-792-3172

Date: _____

Patient Name: _____

Address: _____

Phone #: _____ Cell Phone #: _____

DOB: _____ Email Address: _____

Age: _____ Ht (cm): _____ Wt (kg): _____ Gender: _____ SS#: _____

Ethnicity:
☐ White
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Black/African American
☐ Hispanic/Latino
☐ Other: _____

Diagnosis: _____

Referring MD (GI): _____

Address: _____

Phone #: _____ Fax #: _____

Referring MD (Primary): _____

Address: _____

Phone #: _____ Fax #: _____

Did patient ever have an alcohol problem? ☐ Yes ☐ No
Is patient currently drinking? ☐ Yes ☐ No
If not drinking, when did patient stop? _____
Has patient attended alcohol rehabilitation in the last 2 years? ☐ Yes ☐ No

Did patient ever have a problem using drugs non- therapeutically? ☐ Yes ☐ No
Is patient currently using drugs non-therapeutically? ☐ Yes ☐ No
If not, when did patient stop? _____
Has patient attended drug rehabilitation in the last 2 years? ☐ Yes ☐ No

Did patient ever smoke? ☐ Yes ☐ No
Is patient currently smoking? ☐ Yes ☐ No
If not smoking, when did patient stop? _____

Referral should include:
☐ Completed referral form
☐ Copy of insurance cards (front & back)
☐ Clinical Summary and Discharge Summary
☐ Medication list

If available, include:
☐ Lab data for previous 2 years
☐ Endoscopy, Biopsy & Imaging reports
☐ Men: PSA (age > 40)
☐ Details of alcohol/drug rehab (if applicable)
☐ Abdominal operation reports
☐ Women: Pap smear (age > 18), Mammo (age > 40)

Referring Physician Signature: _____ Phone #: _____
Referring Printed Name: _____