

**VANDERBILT LIVER TRANSPLANT PROGRAM  
REFERRAL WORKSHEET**

1313 21<sup>st</sup> Avenue South, 801 Oxford House \* Nashville, TN 37232-4753  
Phone: (615) 936-5321 \* Fax: (615) 936-2787

DATE REFERRAL RECEIVED: \_\_\_\_\_ VUMC MR #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
\_\_\_\_\_ Home Phone #: \_\_\_\_\_  
\_\_\_\_\_ Work Phone #: \_\_\_\_\_  
\_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Office Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Office Fax #: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Hepatic Diagnosis: \_\_\_\_\_  
Etiology of Liver Disease: \_\_\_\_\_  
Date of Liver Biopsy: \_\_\_\_\_

Insurance Information: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Company: \_\_\_\_\_ Company: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
Group #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_

OON (Out of Network) Referral Needed: \_\_\_ Yes \_\_\_ No OON Referral #: \_\_\_\_\_  
If subscriber other than patient:  
Subscriber Employer: \_\_\_\_\_  
Subscriber SSN: \_\_\_\_\_ D.O.B \_\_\_\_\_

Appointment Date and Time \_\_\_\_\_ w/Dr. \_\_\_\_\_

Conditions Excluding Transplantation from Consideration:  
Is Patient Hepatitis-B Surface Antigen (HBsAg) positive? \_\_\_\_\_  
Is Patient HIV antibody positive? \_\_\_\_\_  
Does the patient have a diagnosed /suspected malignancy or H/O malignancy? \_\_\_\_\_

Personal and Social History:  
Is there any history of alcohol or drug abuse / dependency? \_\_\_\_\_  
If yes, date of last use reported by patient / family \_\_\_\_\_  
Completion of formal rehabilitation program? \_\_\_\_\_  
Participation in abstinence support program? \_\_\_\_\_  
Recent random drug screens done and results? \_\_\_\_\_

Does the patient presently use tobacco? \_\_\_ Yes \_\_\_ No

Complications of Liver Disease:  
Encephalopathy \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
GI Bleeding \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Ascites \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Peritonitis \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_

Medical History:  
Cardiac Disease \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Diabetes \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Renal Disease \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Lung Disease \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Abdominal Surgery \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Psychiatric \_\_\_ Yes \_\_\_ No Details: \_\_\_\_\_  
Other \_\_\_\_\_

