EMORY
TRANSPLANT CENTER

Thank you for your referral to the Emory Liver Transplant Program.
In order to facilitate your patient's evaluation, please complete this form in its entirety.
It is extremely important to provide the necessary information to expedite the patient's evaluation.

Referring Physician:_______________________________________

Practice Name:____

Referring Address:____

Phone Number:____

Fax Number:____

Patient Information

Patient (Last) Name:____

Patient (First) Name:_______________________________________ MI:____

SSN:____

Street Address:____

City:________________________________ State:______________

Zip:____

Primary Phone:____

Secondary Phone:____

DOB:_______________Race:_________________________Gender:_____________________

Email:_______________________________Occupation________________________________

Language of Choice:____________________

Emergency Contact:_____________________Phone:____

Relationship to Pt:______________________________

Insurance Company:___________________________Policy Number:____________________________

Insurance Subscriber:___________________________ Relationship to Pt:_________________________

Required Documentation

Fax Documents to: 404-712-2769

- ☐ Primary Insurance Cards: front & back copy
- ☐ Secondary Insurance Cards: front & back copy
- ☐ Photo ID
- ☐ 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)
- ☐ Recent Abdominal Imaging
- ☐ Diagnostic Tests

Completed by: ______________________________ Phone:________________________________

Address:_____________________________________ Fax:__________________________________

Once we receive all referral patient information requested on this form, the patient will typically be seen within 2-6 weeks. We will also notify the patient regarding appointment date/time, test results, treatment, & diagnostic information. We will provide visit notes to your office using the contact information provided above.