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:_____

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.

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