

- 1 University of Kentucky A.B. Chandler Hospital
- 1 UK HealthCare Good Samaritan Hospital
- 1 UK HealthCare Ambulatory Services
- 1 UK Dental and Oral Health Clinics

Clinic Location

- Lexington
- Louisville (in collaboration with Norton Healthcare)
- Northern Kentucky

University of Kentucky Transplant Center - LIVER TRANSPLANT AND HEPATOBILIARY SURGERY CONSULTATION FORM

To ensure your request is processed as quickly as possible, please fax this form, any supporting information and your cover sheet to **(859) 257-3644**. To speak with a representative directly, call toll-free (888) 808-3212 (select option 1 when prompted) or in Lexington (859) 323-8500 (select option 1 when prompted). We appreciate your referral and look forward to working with you and your patients.

If available, please provide the following items with this fax:

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| <ul style="list-style-type: none"> <input type="checkbox"/> Patient demographic sheet <input type="checkbox"/> Medication list <input type="checkbox"/> Radiology testing (MRI, CT Scan, DUS) <input type="checkbox"/> CD copy of images to be mailed <input type="checkbox"/> EGD and colonoscopy <input type="checkbox"/> Recent history and physical and / or discharge summaries | <ul style="list-style-type: none"> <input type="checkbox"/> Most recent laboratory results, including creatinine, total bilirubin and INR <input type="checkbox"/> Any previous cardiac testing (EKG, stress test, echo, cath) and chest x-ray <input type="checkbox"/> Copy of insurance cards (front and back) <input type="checkbox"/> Liver work-up labs (serologies, genotype, ferritin levels, etc.) <input type="checkbox"/> Social work notes |
|--|---|

Patient Information:		Name:		Date of Birth:	
<input type="checkbox"/> Liver Transplant / Liver Failure			<input type="checkbox"/> Surgical (Hepatobiliary and Liver Lesions)		
Mailing Address:					
City:		State:	Zip:	Phone:	
SSN:		Diagnosis:			
Secondary Contact (Name):			Secondary Contact (Phone):		
Maiden Name:			Mother's Maiden Name:		
Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Referring Physician Information:		Specialty:		NPI:	
Name:		Phone:		Fax:	
Street Address:					
City:		State:	Zip:	County:	
Email of Physician:			Contact Person:		

Primary Care Physician Information:		NPI:			
Name:		Phone:		Fax:	
Street Address:					
City:		State:	Zip:	County:	
Email of Physician:			Contact Person:		

This form can be found online at www.ukhealthcare.uky.edu/transplant/