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

MUSC Health
TRANSPLANT CENTER

ASCREENCRIT

Referral for Post Liver Transplantation Follow-Up

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
Email: LiverTransplant@musc.edu

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: _____

Date of Transplant: _____ Pre-Transplant Diagnosis:_____

Referring Physician Information

Referring MD (GI): _____

Address: _____

Phone #: _____ Fax #: _____

Referring MD (Primary): _____

Address: _____

Phone #: _____ Fax #: _____

Referral should include:
- ☐ Completed referral form
- ☐ Copy of insurance cards (front & back)
- ☐ Medication list
- ☐ History & Physical and/or Discharge Summary
- ☐ Transplant flow chart (complications, rejections, treatment)
- ☐ Operative report, including any procedures performed

Referring Physician Signature: _____ Phone # _____

Referring Physician Name (Printed) _____

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