UNC Liver Center
CB#7584 Burnett-Womack Bldg
Chapel Hill, NC 27599-7584
Phone: 919-966-2516 Fax: 919-966-3414

HEPATOLOGY NEW PATIENT REFERRAL FORM

Date: _____

If your patient has an urgent liver problem, please call Carolina Consultation (1-800-862-6264) or the Operator (919-966-4131). Ask for the attending hepatologist on call. Otherwise complete this form and fax it to us along with copies of pertinent clinic notes, endoscopy reports, pathology reports, labs, imaging results and discharge summaries. We cannot schedule an appointment without this information.

Patient Information **UNC MR# (*if known*):**

LAST NAME:	FIRST NAME:		MIDDLE NAME:
Primary phone:	Alternate phone:	Gender: F ☐ M ☐	Birth Date:
Street address:			
City:	State:	Zip:	

Specific Reason (diagnosis, symptoms, and/or issue to be address) for Hepatology Consultation:

_____

_____

Is this referral for a Liver Transplant Evaluation ☐ Yes ☐ No

If yes, please write in the following latest lab values: INR _____, Bilirubin _____, Creatinine_____, Na _____

Is this referral for a suspected/known liver cancer or liver mass? ☐ Yes ☐ No

Does your patient have active drug/alcohol abuse? ☐ Yes ☐ No

Is an interpreter needed? ☐ Yes ☐ No. If yes, what language? _____

Request patient be seen at:

☐ **UNC Liver Center, Chapel Hill (All hepatology including transplant and viral hepatitis treatment)**
☐ **UNC High Point Liver Practice, High Point (All hepatology including transplant and viral hepatitis treatment)**
☐ **UNC Rex Liver Practice, Raleigh (No viral hepatitis treatment administered through this clinic.)**
☐ **UNC ECU Liver Practice, Greenville (All hepatology including transplant and viral hepatitis consultation.)**
☐ **UNC New Hanover Liver Practice, Wilmington (No viral hepatitis treatment administered through this clinic.)**
☐ **UNC Liver Practice, Asheville (All hepatology including transplant and viral hepatitis consultation)**

REFERRING PROVIDER INFORMATION		
Provider Name:		
Practice Name:		
Street Address:	**City, State, Zip**	
PHONE:	**FAX:**	**EMAIL ADDRESS:**

INSURANCE INFORMATION (*PLEASE ALSO ENCLOSE COPY OF INSURANCE CARD*)			
POLICY HOLDER'S RELATIONSHIP TO PATIENT: ☐**SELF** ☐**PARENT** ☐**SPOUSE** ☐**CHILD** ☐**OTHER**	**LAST NAME:**		**FIRST NAME:**
SEX: F ☐ M ☐	**BIRTH DATE:**		**PRIMARY PHONE:**
PRIMARY INSURANCE CARRIER:	**POLICY #:**	**GROUP #:**	**EFFECTIVE DATE:**
SECONDARY INSURANCE CARRIER:	**POLICY #:**	**GROUP #:**	**EFFECTIVE DATE:**