

**Fax**

**To:** \_\_\_\_\_ **From:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **RE:** \_\_\_\_\_

You referred this patient to **UCSF for LIVER TRANSPLANT evaluation**. In order to schedule an appointment, include the following minimum information (**previous 6 months only**):

- Completed** UCSF Liver Referral Form
- Most recent **H&P or clinic note** which should include cause of liver disease (*i.e. alcohol, Hep C, etc.*)
  - Provide the date of patient's last drink on Referral Form, patient must have 6 months sobriety to be considered for transplant evaluation
- Most recent **abdominal imaging study** (*MRI, CT, and/or ultrasound*)
  - Other test reports if done: *cardiac records (ECG, echo, stress test, cath), PFTs, ABGs, EGD, colonoscopy, liver biopsy*
- Most recent **lab work including MELD-sodium labs** (*albumin, total bilirubin, creatinine, sodium, INR*)
  - The **MELD-sodium Score (MELD-Na)** should be calculated and included on referral form, it is used to determine priority of patient referral
  - **If MELD-sodium Score (MELD-Na) is greater than 25**, please contact our **Transplant Evaluation Nurse Coordinator at 415-353-1888**
- Authorization for Liver Transplant Evaluation: **see attached Authorization form with CPT codes**. Obtain authorization to expedite patient's appointment. For financial questions, call 415-353-1888.
  - Patient's **insurance** information, including copy of both sides of insurance card
  - Patient's **demographics** and contact information (complete on Referral Form AND attach demographic sheet that includes the same information requested)
- If a liver cancer (HCC) patient**, please include:
  - Abdominal CT or MRI report that **FIRST DIAGNOSED HCC** (*needed to list the patient*)
  - All abdominal CT and MRI reports done since diagnosis of HCC (*also needed for listing and review*)
  - CD with **BOTH** the most recent abdominal imaging study (*CT or MRI; not ultrasounds*) **AND** the original CT or MRI first diagnosing HCC.
  - All treatment reports, if done: *Chemo-embolization, radio-frequency ablation, etc.*, recent chest CT report, and recent AFP

**ATTENTION:** We can NOT schedule a liver transplant evaluation until we receive the information requested above. If we do not receive in 2 weeks or after three requests, the referral will be canceled and no appointment will be made.

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**FAX REPORTS TO:** 415-353-2102

**ATTN:** New Referrals

**PHONE:** 415-353-1888, OPTION 0

**MAIL CD TO:** UCSF LIVER TRANSPLANT PROGRAM  
ATTN: NEW REFERRALS  
350 PARNASSUS AVE, SUITE 805  
SAN FRANCISCO, CA 94117

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**THANK YOU!**

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