

Liver Care Line CONSULTATION REQUEST

This form is to be completed by a referring physician or designee. Fields with titles marked by an asterisk are required entries and must be completed before the request can be processed. For additional information please visit <http://www.uwmedicine.org/>.

PATIENT NAME*		
DATE OF BIRTH*	GENDER?* <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SSN	<input type="checkbox"/> INTERPRETER NEEDED; LANGUAGE?*	
ADDRESS*		
CITY*	STATE	ZIP*
HOME PHONE*	WORK PHONE	
CELL PHONE	PCP	
INSURANCE		

FROM:

PROVIDER NAME*		
ADDRESS		
CITY	STATE	ZIP
PHONE*	FAX*	

TO:

DEPARTMENT	SPECIALTY	
PROVIDER NAME		
TYPE?	<input type="checkbox"/> MD	<input type="checkbox"/> PA-C
	<input type="checkbox"/> EITHER	<input type="checkbox"/> ROUTINE <input type="checkbox"/> URGENT

CONSULT REASON*	
PERTINENT DIAGNOSIS*	
REFERRING PROVIDER SIGNATURE*	DATE

UWMC Liver Care Line

- Hepatology
- Liver Transplant
- Liver Tumor Care

Referral Phone: 206-598-4973
 Referral Fax: 206-598-4287
 Liver Care Line Phone: 206-598-8882
www.uwgi.org/liver

LIVER CARE & TRANSPLANTATION