

Referral Form

Here are a list of questions we need answered so we can register you in our data base. Once we receive the referral/request your physician we contact you to get these questions answered or can complete the form and email it or fax it to us. Our fax number is 305-355-5970 and our email is MTILiverinfo@med.miami.edu

- ❖ Your full name (as stated on your social security card/driver's license)
- ❖ Your date of birth (Month – Day – Year)
- ❖ Your nationality and country of citizenship?
- ❖ Height (specify inches or cm) and Weight (specify pounds or kg)
- ❖ Your mailing address including the county/province you live in and zip code/postal code.
 - Street Address:
 - Apt Number:
 - City:
 - County:
 - State:
 - Zip code:
 - Home phone#:
 - Cell phone#:
 - Work phone#:
 - Email address:
- ❖ Additional contact person who speaks English in case of an emergency– Relation to patient, Name, Home Phone#, Cell Phone # & address.
 - Full Name:
 - Relationship to patient:
 - Street Address:
 - City:
 - State:
 - Zip Code:
 - Home phone#:
 - Cell phone#:
 - Work phone#:
- ❖ Your spouse's full name
- ❖ How many children do you have in total?
- ❖ Your mother's first name and maiden name (last name before she was married).
- ❖ Place of birth (city, state, country)
- ❖ What is your religion?
- ❖ Employment status? Full-time, Part-time and why? Not working- why?
- ❖ Occupation/Profession?
- ❖ Education Level? Elementary School, High School, College- Associate/Bachelors or Post College Graduate(MD, PhD, Lawyer Etc)

- ❖ Your primary care doctor or your family doctor. Name, Phone, Fax, email and Address.
 - Doctor's name (first and last)
 - Address
 - Phone#
 - Fax#

- ❖ Your Liver specialist or Gastroenterology doctor. Name, Phone, Fax, email and Address
 - Doctor's name (first and last)
 - Address
 - Phone#
 - Fax#

- ❖ Your medical diagnosis- what is causing your liver disease?

- ❖ Have you had any of the following?
 - Bleeding in your stomach or esophagus or vomited a large amount of blood- if yes how many times and when was the last time?
 - Blood transfusion- if yes when was the last time?
 - Cancer- if yes when, what kind and how was it treated?

- ❖
 - Any surgeries? Especially in the chest or abdomen. What kind and when?

 - Allergies to food or medication? If yes, specify type/name of medication
 - Are you diabetic? If yes- Insulin or Non-insulin dependent? Age you were diagnosed with diabetes

 - Signs of confusion or forgetfulness or tremors in the hands or feet or abnormally high ammonia levels in your blood (Encephalopathy)?
 - Retaining fluid or holding large amounts of fluid/water in your abdomen, arms or legs (Ascites)?

- ❖ Have you ever drunk any kind of alcohol? If yes- are you currently drinking alcohol? How much and how often? Did you ever go to a rehabilitation program for alcohol abuse?

- ❖ Have you ever smoked a tobacco product? If yes- are you still smoking? How much and how often?

- ❖ Have you ever done any illegal drugs? If yes are you still doing them? What kind? How often? Did you ever go to a rehabilitation program for drug abuse?

- ❖ Current list of all your prescribed, over the counter and herbal or natural medications. Provide name, dose and how often you take each medication:

Needed Records (refer back to checklist)

- ❖ Current detailed History & Physical, Clinic note or consult note
- ❖ Any applicable surgical or operative notes
- ❖ Current Labs including Chemistry, CBC, hepatic function test, ABO(blood) Typing, AFP
- ❖ Current diagnostic testing reports (**these should be less than 6 months old**)
 - CT/MRI's of abdomen & pelvis
 - Liver Biopsies
 - Kidney biopsy (if applicable)
 - Ultrasounds of abdomen & pelvis- Especially Doppler Ultra Sound of Liver
 - 24 Hour Urine with creatinine clearance
 - upper endoscopy
 - Colonoscopy
 - EKG
 - chest x-ray
 - Stress echocardiogram

You will need to obtain a copy of your last CAT scan/MRI and bring the disc to your first clinic visit.

Thank you in advance for your help with getting us this information. If you have any questions or concerns, please feel free to contact us either by e-mail or phone at **305-355-5095** (there is usually someone at this number 24 hours a day 7 days a week).

Our office phone number is **305-355-5160 (8am-5pm Mon-Fri)**

Our fax number is **305-355-5790**.

Our address is:

**Miami Transplant Institute
Highland Professional Building
Third Floor
Transplant Center
1801 NW 9th Avenue
Miami, FL 33136**

Sincerely,

Pre-Liver/GI Transplant