SWEDISH MEDICAL CENTER
FIRST HILL CAMPUS

Date: _____

FAX: 206-320-7431

Referring Provider Information

Referring Physician

Name: _____

Address: _____

_____

Phone # _____

Fax #: _____

Primary Care Physician ☐ same as Referring

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Patient Information

☐ FACE SHEET ATTACHED

DOB: _____ SSN: _____

Name: _____ Home / Alt Phone: _____

Address: _____ Insurance: _____

_____ ID#: _____ Group #: _____

Reason for Referral

Primary Liver Diagnosis:

❒ HCV ❒ HCV Treatment ❒ HBV ❒ Alcohol ❒ Abnormal Liver Enzymes ❒ Autoimmune

❒ NASH/NAFLD/fatty liver ❒ Hemochromatosis ❒ Wilson Disease ❒ PBC ❒ PSC

❒ Hepatocellular Carcinoma ❒ Cholangiocarcinoma ❒ Other _____

❒ Surgical Consultation for: _____ ❒ Other _____

Specific MD Requested? ❒ No ❒ Yes

Hepatology: ❒ Larson ❒ Fix ❒ Kowdley ❒ Ness ❒ Procaccini ❒ Mukhtar

Hepatobiliary Surgery: ❒ Hart ❒ Precht

What question would you like addressed?

❒ Opinion regarding patients liver disease.

❒ Potential surgical resection candidate.

❒ Other: _____

❒ Is patient a transplant candidate?

_____

_____

The Liver Center & Liver Transplant Clinic at Swedish
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