



Texas Liver Institute Referral Form

Patient Information

First Name: _____

Last Name: _____

Date of Birth: _____ / _____ / _____

Patient Insurance: _____

If Under 18, Guardian Name: _____

Home Phone: _____

Cell Phone: _____

Referring Provider Information

Name: _____

Email: _____

Practice Name: _____

Specialty: _____

Address: _____

Phone: _____

Fax: _____

Office Contact: _____

Date of Referral: _____

- Hepatology Consultation
- FibroScan/Elastography
- University Transplant Referral
- Other, Specify: _____

Medical Information

- | | |
|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Elevated Liver Enzymes | <input type="checkbox"/> Autoimmune Hepatitis |
| <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> PBC |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> PSC |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Abnormal Imaging |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Tumor/Liver Cancer |
| <input type="checkbox"/> Ascites | <input type="checkbox"/> Other: _____ |

- If the patient is being referred ONLY for FibroScan/Elastography please check the box

Other/Comments: _____

Please include the following information:

- ▶ Medical records (including imaging, labs and progress notes)
- ▶ Demographics
- ▶ Insurance card

**Fax referrals to our central referral center (210.237.4807)
or email referrals to referrals@txliver.com**

Please select the office you are referring the patient to:

Dallas

7515 Greenville Ave, Suite 600
Dallas, TX 75231
Phone: 214-945-2521

San Antonio

607 Camden St, Suite 101
San Antonio, TX 78215
Phone: 210.253.3426

Austin

7940 Shoal Creek Blvd, Suite 205
Austin, TX 78757
Phone: 512.454.8378