American Research Corporation at the

Texas Liver Institute

Research Referral Form

This form is to refer patients directly for clinical trials and not for a consultation.

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: _____

Clinical Trial Referral For The Following Condition:

- ☐ Fatty Liver (NASH)
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Cirrhosis
- ☐ Autoimmune Hepatitis
- ☐ Liver Cancer
- ☐ Primary Biliary Cholangitis (PBC)
- ☐ Primary Sclerosing Cholangitis (PSC)
- ☐ Other: _____

Please include the following patient information:

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

Fax all research referrals to 855.205.8983

American Research Corporation at the Texas Liver Institute

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Phone: 210.253.3426

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