Information Session on Clinical Research

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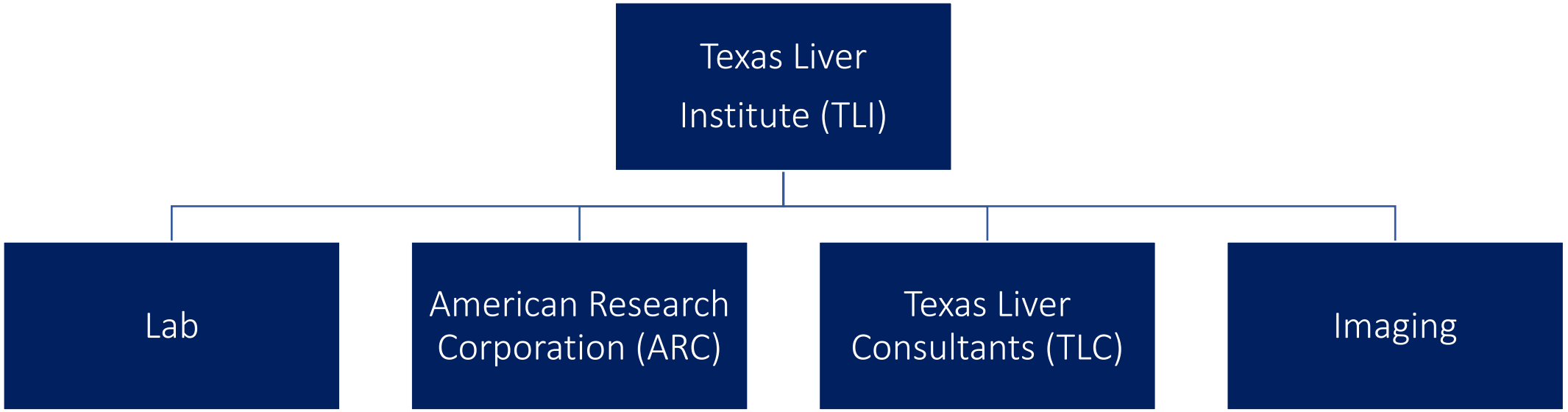
Texas Liver Institute

Who We Are, What We Do…



American Research Corporation (ARC)

TLI’s Research Center

Texas Liver Institute

Hepatology Disease States Under Study

- Steatotic liver disease (MASLD/MASH)
- Autoimmune liver diseases
- Hepatocellular cancer
- Cirrhosis complications
- Portal hypertension
- A1AT deficiency
- Hepatitis B
- Primary Biliary Cholangitis (PBC)
- Primary Sclerosing Cholangitis (PSC)

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Clinical Research

- There is zero charge to the patient
- Uninsured/underinsured patients are eligible
- Studies offer free medical care to participants (study defined labs, imaging, etc.)
- Many studies offer a stipend for participation
- Travel costs are always covered
- Phase 2 & 3 studies offer the patient cutting edge therapies prior to FDA approval

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Referral Forms (See Page 11 in Meeting Guide)

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 210.253.7744

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

- ☐ Elevated Liver Enzymes
- ☐ Fatty Liver
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Cirrhosis
- ☐ Ascites
- ☐ Autoimmune Hepatitis
- ☐ PBC
- ☐ PSC
- ☐ Abnormal Imaging
- ☐ Tumor/Liver Cancer
- ☐ 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

Questions?

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