# UW Medical Center Liver Care Line Referral Checklist

Thank you for your interest in the Liver Care Line at UW Medical Center.

This form is a guideline for proper referral documentation. It is intended to serve only as an outline and does not need to be included in the actual referral. Additional information, visit www.uwmedicine.org/liver

Please send items from the below checklist in order to expedite appointment scheduling. Please ensure the information sent is current, as outdated records will result in a delay or denial or the referral.

**CONSULTATION REQUEST**
- ○ Patient Demographics
- ○ Referral Reason

**PROGRESS NOTES**
- ○ History & Physical
- ○ Alcohol/Drug History

**INSURANCE INFORMATION**
- ○ Insurance Name/Type
- ○ Subscriber Name/
- ○ SSN *(required for transplant referrals)*
- ○ Policy/Group #
- ○ Benefits Phone #

**LABORATORY STUDIES**
- ○ COMP Metabolic Panel
- ○ CBC with Platelet Count
- ○ AFP (non-maternal)
- ○ PT/INR
- ○ HCV RNA Quant. *(test result is required for all referrals for HCV treatment, HCV Ab is not sufficient)*

*Also, include the following documentation, if available:*

**RADIOLOGY REPORTS**
- ○ Ultrasound
- ○ CT Scan
- ○ MRI

**PATHOLOGY RESULTS**
- ○ Liver Biopsy

The patient will be scheduled for a clinic visit as soon as the preceding paperwork has been received and reviewed. We will contact the patient directly to set up an appointment.

Referral Fax: 206.598.4287
Referral Phone: 206.598.4973

# UW Medical Center Liver Care Line Consultation Request

This form is to be completed by a referring physician or designee. Fields with titles marked by an asterisk are required entries and must be completed before the request can move forward.

| | |
|---|---|
| PATIENT NAME* | |
| GENDER* | |
| DATE OF BIRTH* | |
| SSN | |
| INTERPRETER NEEDED; LANGUAGE? | |
| ADDRESS* | |
| CITY/STATE/ZIP* | |
| PRIMARY CARE PROVIDER | |
| HOME PHONE* | |
| CELL PHONE | |
| INSURANCE | |

**FROM:**

| | |
|---|---|
| PROVIDER NAME* | |
| NPI | |
| ADDRESS | |
| CITY/STATE/ZIP | |
| PHONE* | |
| CONSULT REASON* | |
| PERTINENT DIAGNOSIS* | |
| REFERRING PROVIDER SIGNATURE* | |
| DATE | |

Referral Fax: 206.598.4287

Referral Phone: 206.598.4973