ARIZONA DIGESTIVE HEALTH
powered by GI Alliance

Liver Disease Referral Form

Fax to _____

Patient's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact Phone: _____
Responsible Party: _____
Contact Phone: _____
Insurance: _____

Diagnosis: _____
Referral is: _____ Urgent _____ Elective

Check all that apply:

- ☐ Liver Transplant Evaluation
- ☐ Hepatocellular Carcinoma Evaluation
- ☐ Hepatitis C Treatment
- ☐ Hepatitis B Treatment
- ☐ Hepatology Consultation
- ☐ Diagnostic Dilemma
- ☐ Second Opinion
- ☐ Other: _____

Comments: _____
_____

BANNER LIVER DISEASE CENTER Fax Back Number: _____

Appointment made on _____with _____

Please send:

- ☐ CD's of imaging
- ☐ Office Records
- ☐ Hospital records

Please obtain:

- ☐ HCV RNA
- ☐ HCV Genotype
- ☐ MELD score labs (Bili, Creat, INR)