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

Please select the American Research Corporation at the Texas Liver Institute office you are referring the patient to:

☐ **San Antonio**
607 Camden St, Suite 101
San Antonio, TX 78215

☐ **Austin**
7940 Shoal Creek Blvd, Suite 205
Austin, TX 78757