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: ____________________

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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: ____________________

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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

Please select the office you are referring the patient to:

☐ San Antonio
607 Camden St, Suite 101
San Antonio, TX 78215
Phone: 210.253.3426

☐ Austin
7940 Shoal Creek Blvd, Suite 205
Austin, TX 78757
Phone: 512.454.8378

www.txliver.com