Texas Liver Institute
www.txliver.com

Please Fax Patient's Records, Demographics and Insurance Card.

RESEARCH TRIAL Referral Form

This form is to refer patients directly for clinical trials and not for consultation.

For clinical referrals, please use the Hepatology Referral Form.

REFERRING PROVIDER INFORMATION

Physician Last Name _____ Physician First Name _____

Office Address _____ Date of Referral _____

Phone _____ Fax _____

CLINICAL TRIAL REFERRAL FOR:

- ❑ HEPATITIS C
  - ○ Treatment Naive (Never Treated)
  - ○ Treatment Failure
  - ○ Interferon Intolerant
  - ○ Protease or other Direct Active Antiviral Failures
- ❑ FATTY LIVER (NASH)
- ❑ CIRRHOSIS (ANTI-FIBROTIC TREATMENTS)
- ❑ ENCEPHALOPATHY

Sending medical records will greatly expedite the trial evolution process, particularly biopsy and imaging data for hepatitis C, past treatment start/stop dates and viral loads.

Most trials are fully funded and insurance is not required.

Thank you for referring your patients to the Texas Liver Institute.

PATIENT INFORMATION

Patient Last Name _____ Patient First Name _____

Patient Date of Birth _____ Patient Insurance (if available) _____

This box to be completed by Texas Liver Consultants Scheduling

Appointment Date/Time _____

Patient Notified Date _____ By _____

Refer. Office Notified Date _____ By _____

Texas Liver Institute locations:

San Antonio Central
607 Camden, Suite 108
San Antonio, Texas 78215
Fax Referrals:
210.227.2572
Phone: 210.253.3426

Austin
1111 34th St., Suite 210
Austin, Texas 78705
Fax Referrals:
512.454.8375
Phone: 512.454.8378