Barnes-Jewish Hospital Liver Transplant Referral Form

FOR HELP OR QUESTIONS PLEASE CALL:
314-362-5376 or **800-295-4734**

To submit online, go to
barnesjewish.org/transplantreferral

Email completed form to
gs-livertxp@bjc.org

Fax completed form to
314-362-5468

Mail form to
Liver Transplant Center
4590 Nash Way
MS 90-29-908
St. Louis, MO 63110

Date _____

Referring Physician _____

Referring Physician Phone (_____) _____

Referring Physician Fax (_____) _____

Primary Care Physician _____

Primary Care Phone (_____) _____

Primary Care Fax (_____) _____

_____

Patient Name _____ **DOB** / / **SSN** _____

Address _____

City _____ ZIP _____

Patient Contact: (Please check preferred contact number)

☐ **Home** (_____) _____ ☐ **Cell** (_____) _____ ☐ **Work** (_____) _____

Patient Height _____ Patient Weight _____

Diagnosis(es) _____

_____

Additional Comments _____

_____

Required Insurance Information: Please fill out and attach a copy of the front and back of the insurance card(s):

Primary Insurance Name and Phone_____

_____

Policy #_____ Group #_____

Secondary Insurance Name and Phone_____

_____

Policy #_____ Group #_____

Please forward copies of patient's most recent labs, history and physical, radiology reports, and biopsy reports. *These items are necessary for our team to process your referral.*

We will contact your patient to begin the evaluation process.

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