METHODIST TRANSPLANT INSTITUTE

Surgery Referral Form

(Hepatobiliary/Pancreatic/Vascular Access/General)

Fax Referrals to 901.516.8497

PATIENT INFORMATION

Patient's Name: _____ DOB: ____/____/____ Gender: ❑ Female ❑ Male

Address: _____

Daytime Phone: (____) _____ Alternate Phone: (____) _____

Interpreter needed? ❑ Yes ❑ No If yes, what language? _____

Has patient started dialysis? ❑ Yes ❑ No Dialysis Schedule: _____ Dialysis Unit: _____

Phone: (____) _____ Fax: (____) _____

Social Security #: _____

INSURANCE INFORMATION

Health Plan: _____ Group #: _____ Member ID: _____

Secondary Insurance: _____

MEDICAL INFORMATION

Diagnosis/Reason for referral: _____

Is this an urgent referral? ❑ Yes ❑ No If yes, please call **901.478.9183**.

Reason for urgent referral: _____

Co-Morbids: _____

REFERRING MD CONTACT INFORMATION

Referring MD: _____ Best way to reach: ❑ Phone ❑ Pager

Phone (____) _____ Fax (____) _____ Pager (____) _____

ATTACHMENTS

Please note: Sending the items below helps us give your patient the most effective care.

Insurance cards, medical record notes, medication list, pertinent operative notes, results of diagnostic/imaging studies including CD, pertinent lab studies

Signature of person completing form:

_____

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For additional information, please call **901.478.9183**.