Atrium Health

HEPATOLOGY AND LIVER TRANSPLANT

Date: _____ Clinical in Cerner: ☐ Yes ☐ No

Patient Information

Patient's name: _____ ☐ Male ☐ Female DOB: ____/____/____

Marital status: _____ Race: _____ SSN: _____-_____-_____

Address: _____
Street City State Zip

Email address: _____

Home phone: (____) _____ Cell: (____) _____ Work: (____) _____

Emergency contact name: _____ Relationship to patient: _____

Home phone: (____)_____ Cell: (____) _____

Insurance Information - Submit Copy of Card (front and back)

Referral Location

☐ Atrium Health Liver Care and Transplant, Charlotte, NC
Phone: 704-355-6649
Fax: 704-446-4870

☐ CHS Liver Care Pineville
Phone: 704-667-1550
Fax: 704-667-1551

☐ CHS Liver Care Columbia
Phone: 704-355-6649
Fax: 704-446-4870

☐ CHS Liver Care Greensboro
Phone: 336-235-0866
Fax: 336-235-0868

☐ CHS Liver Care Greenville
Phone: 864-675-5844
Fax: 864-675-5865

Practice Information

Referring provider: _____ Reason for referral: _____

Practice name: _____ Office contact: _____

Address: _____
Street City State Zip

Phone number: _____ Fax number: _____

What service are you requesting?

☐ Transplant referral

☐ Office visit only

☐ Office visit with FibroScan*

☐ FibroScan only (CPT Code 91200)*

Please send the following:

☐ Recent labs

☐ Copy of CT disk/pathology slides

☐ Recent office note

☐ Radiology imaging

* Referring office must obtain authorization for the FibroScan before appointment

****Office Use Only****

Appointment date: _____ Time: _____ Provider name: _____

Center for Liver and Digestive Disease: Referral Form