Hepatology Referral Form

Date: ___/___/___

To begin our assessment the following information is **required**. Please use the form to ensure **ALL REQUIRED** documents are received. Please send the patient's records and demographics (**including a copy of driver's license and insurance card**). The required information and financial clearance must be received ***before referrals are processed***. Please fill out form entirely. **Any incomplete or missing information will result in the referral being delayed.**

Patient Information : Name (Mr/Mrs, First-middle-last, Jr/Sr) : _____

Language: _____ Race: _____ Ethnicity: _____ Gender: M F SSN#:_____

Address: _____City _____State _____ Zip _____

Phone#: (_____)_____ DOB: _____Age: ___

Reason for referral: _____ Diagnosis:_____

******REQUIRED CLINICAL INFORMATION TO PROCESS THIS REFERRAL******

☐ Recent Visit/Progress Notes ☐ Diagnostic MRI, CT, US reports
☐ Any "lab or procedure document/result that was done for liver disease"
☐ Current Labs (within 1yr, last 3 results): CBC, Chemistry, INR, AFP, Any liver specific labs
◊ If Hep C: Last Viral Load Genotype ◊ Hep A & B Serologies
IL 28 if done

Referring MD: _____ Specialty: _____

Address: _____City_____ State _____Zip _____

Phone #: (_____)_____ FAX #: (_____)_____ Contact Person:_____

PCP: _____Address:_____

Phone# (_____) _____ FAX#(_____) _____

Insurance Information: If patient has HMO plan, they must provide copy of referral authorization prior to first appointment.

Insurance Co #1: _____
Insured: _____
Insured DOB#: _____
Policy#: _____
Group#: _____
Phone# _____

Insurance Co #2: _____
Insured:_____
Insured DOB#: _____
Policy#: _____
Group#: _____
Phone# _____

Has the insurance company been notified of referral? YES ☐ NO ☐ Authorization #: _____

PLEASE FAX INFORMATION TO:

TGMG Case Management Department
409 Bayshore Blvd Tampa, FL 33606
Phone: (813) 844-5507
Fax#: (813) 844-1921

FOR OFFICE USE ONLY

MR#: _____ **Referral#:** _____

Comments:
_____
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