PennState Health
Milton S. Hershey Medical Center

Solid Organ Transplant Program
Abdominal Transplant
Mail Code A520
90 Hope Drive
Suite 4301
P.O. Box 850
Hershey, PA 17033-0850

717-531-6092
800-525-5395
717-531-3717 Fax

Patient Name: _____

DOB: _____

Height: _____

Current Weight: _____

BMI: _____

Cause of Organ Failure:

_____

_____

_____

Gastroenterologist/Hepatologist or Referring Provider:

Name: _____

Phone: _____

Fax: _____

Primary Care Provider:

Name: _____

Phone: _____

Fax: _____

Special Considerations:

Does this patient have a history of Cancer outside of the liver? If yes, please answer below: **Yes or No**

Specify Type: _____

Date diagnosed: _____

Type of Treatment: _____

Is this patient's primary language English? **Yes or No**

Would an interpreter be helpful? **Yes or No**

Specify language: _____

Is this patient currently list or in the txp eval. Process? **Yes or No**

Center: _____

Phone: _____

Required Documents:

- **Demographic Face sheet**
- **Front and back of all insurance cards**
- **Complete Medical H&P**
- **Current Medications**
- **GI Notes – most recent**
- **CT and/or MRI abdomen - Report & Images**
- **CMP, CBC w/platelets, INR, (if available AFP, CEA and CA19-9)**

Any additional information that you feel is pertinent:

_____

_____

_____

_____

Thank you for this referral. We will fax you notification of transplant evaluation date and time.