Phone: 781-744-2500 **Fax: 1-833-461-0694**

Beth Israel Lahey Health
Lahey Hospital & Medical Center

Lahey Hospital & Medical Center: Transplantation & Hepatobiliary Diseases Referral Form

Thank you for choosing Lahey. We look forward to partnering with you in your patient's care. Please check what the referral is for:

☐ Hepatology ☐ Hepato-pancreato-biliary Consult ☐ Liver Transplant ☐ Routine ☐ Urgent

Date: _____ # of Pages faxed: _____

Referring Provider Information:

Referring MD: _____ Medical Group: _____

Phone: _____ Fax: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

Patient Information:

Last name: _____ First Name: _____ MI: _____

DOB: ____/____/____ Gender ☐ M ☐ F Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Needs Interpreter: ☐ Yes ☐ No Language: _____

Please include complete demographic sheet including insurance information

Reason for Referral (please write out the diagnosis)**:**

Primary Diagnosis: _____ Secondary Diagnosis: _____

Required Documents. Please send with this form or ASAP.
Missing documents may result in delayed scheduling.

☐ H&P/office note
☐ EGD/colonoscopy (pathology report)
☐ Medication/allergy list
☐ Immunization record
☐ Most recent labs
☐ Imaging reports (please include disk if available)
☐ Pathology/biopsy results
☐ Other notes and reports if applicable
☐ Full demographic sheet with insurance information

For internal use only: ☐ Spoke to Patient ☐ Appointment Made ☐ Missing documents

Lahey MRN:

Notes:

_____

41 Mall Road, Burlington, MA 01805
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