Patient Name: DOB:

UNIVERSITY of ROCHESTER MEDICAL CENTER

Solid Organ Transplant & Hepatobiliary Surgery
Inpatient Transfer Worksheet

Dear Physician,

Thank you for your referral to the University of Rochester Hepatology and Liver Transplant Center Program. In order to facilitate your patient's transfer, please use this as a checklist and provide the following records (if available):

- □ **Accompanying completed referral form**
- □ **Demographic face sheet (Name, DOB, social security, insurance information, marital status)**
- □ **Copy of all insurance cards (front & back) - If no insurance, what is plan to obtain?**
- □ **Recent clinical summary including complete physical exam, all current medications (including any prescription and/or herbal medications taken prior to admission) physical therapy or occupational therapy plans and treatment plans.**
- □ **Lab Data over the last 7 days**
- □ **Include any special studies done to aid in the diagnosis (such as serologies) over the past two years**
- □ **Endoscopy/Colonoscopy reports**
- □ **Recent abdominal or any other relevant imaging (Images on disk may be requested if accepted for transfer)**
- □ **Operative reports, especially abdominal**
- □ **Liver Biopsy reports (and slides if accepted for transfer)**
- □ **Recent discharge summaries**

Return this form and all other requested items via fax to the following number: **585.276.1932**

You may contact our office at **585.275.5875** for further questions.

Thank you again for your referral and we look forward to evaluating your patient.

STRONG MEMORIAL HOSPITAL

INPATIENT TRANSFER WORKSHEET

SMH 2067 MR

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Patient Name:

DOB:

URMC Coordinator: _____

URMC ATTENDING: _____

Hospital Name & Phone number: _____

Current diagnosis: _____ **MELD SCORE:** _____

Reason for current hospitalization/referral: _____

Current level of care (circle one): ICU Floor ED

Recent Vital Signs:	
HR:	
Temp:	
BP:	
O2 Saturation:	
Resp:	
Requiring Oxygen:	
On Vasopressors:	
Intubated:	
Height:	
Weight:	

Referring MD Name:
Contact Number:

Primary Care MD Name:
Contact Number:

Patient's Caregiver Name:
Contact Number:

Nutritional status (circle one): Poor Fair Good

Functional status (circle one): Bed Bound Wheelchair Needs Assistance Independent

Current infectious concerns and treatments: Yes No **Isolation:** Yes No

_____

Medical History:		
	Yes	Comments:
Coronary Artery Disease/Myocardial Infarction		
Hypertension		
Emphysema/COPD/Pulmonary Hypertension		
Anemia		
Bleeding Tendency		
Hepatitis		
Kidney Disease		
Dialysis (if yes, type & when started)		
Hepatocellular carcinoma		
Any other cancer		
Diabetes Mellitus		

Blood Work from Today				
WBC:	HCT:	INR:	Platelet:	Sodium:
TB:	AST:	CO2:	ALT:	Potassium:
ALK:	Bun:	Creatinine:	ABO:	

STRONG MEMORIAL HOSPITAL

INPATIENT TRANSFER WORKSHEET

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Patient Name:

DOB:

Mental Health:		
Past or current history of mental health concerns:	**Circle all that apply:** Anxiety Depression Suicide Attempts Self Harm	**Comments:**
Psychiatric Medications:	No Yes	List Medications:
History of Counseling:	No Yes	Current Mental Health Provider: Phone:
Substance Use:		
Smoking:	No Yes	How many cigs/day? How many years smoking?
Alcohol Use:	No Yes	Date of last drink: Concerns about abuse: Frequency of alcohol use: Years of alcohol use: History of DUIS, Rehab programs:
Illicit Drug Abuse (includes Marijuana):	No Yes	Date of last drug use: Types of drugs use: Concerns about abuse: Years of use:
Prescription Drug Abuse:	No Yes	If yes, when and what meds?

Are you willing to accept the patient back to your institution if he/she were deemed not a transplant candidate: Yes or No

Who will resume care at discharge?
Name of MD: