

HEPATO-PANCREATO-BILIARY SERVICE

Consultation/Referral Form

P: 404.605.2868

F: 404.588.2650



1968 Peachtree Road • Atlanta, Georgia 30309
404.605.4600 • piedmonttransplant.org

PATIENT INFORMATION

Name: _____

DOB: _____ Sex: _____ SSN: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Referring Diagnosis: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Facility: _____

Please complete the information below if you have not previously referred to Hepato-Pancreato-Biliary Service at Piedmont.

Address: _____

Phone: _____ Fax: _____ Email: _____

Please fax the following information with this completed form so that we may process your referral as quickly as possible.

- Patient's insurance card/Face Sheet (Demographics)
- Recent H&P/Clinic notes or letter with clinical summary
- Recent labs
- Recent imaging results/reports