DHR Health Transplant Institute

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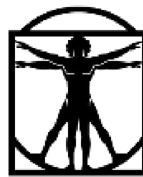

DHRHealth
Transplant Institute
Kidney Transplant Center

PATIENT REFERRAL FORM

☐ PRE-KIDNEY TRANSPLANT ☐ POST-KIDNEY TRANSPLANT

REFERRAL CANNOT BE PROCESSED WITHOUT ALL REQUIRED INFORMATION. PLEASE SUBMIT THE FOLLOWING:

- ☐ Completed referral form (this form)
- ☐ Copy of Picture ID
- ☐ Copy of Insurance Card(s)
- ☐ Copy of HCFA 2728 Form
- ☐ Most recent History & Physical
- ☐ Most recent monthly labs (BMP, CBC, GFR, Creatinine)

PATIENT DEMOGRAPHICS

Patient Name: ____________________ ☐Male ☐Female

Date of Birth: ____________ Age: ______ Social Security Number: ____________

Address *(Street/City/State/Zip)*: ____________________

Home Phone: (______) __________ Cell: (______) __________ Work/Alt. Phone: (______) __________

Preferred Language: ☐English ☐Spanish ☐Other: __________ Marital Status: ☐S ☐M ☐D ☐W

Citizenship: ☐U.S. Citizen ☐U.S. Resident ☐Other: __________

IF MANDATED BY INSURANCE COMPANY, PLEASE NOTIFY PRIMARY CARE PHYSICIAN (PCP) OF THIS REFERRAL.

PCP (if applicable): ____________________ Phone: (______) __________

Primary Insurance: ____________________ Secondary Insurance: ____________________

REFERRING PHYSICIAN INFORMATION

Physician Name: ____________________ Specialty: ____________________

Dialysis Center: ____________________

Address *(Street/City/State/Zip)*: ____________________

Phone: (______) ____________________ Fax: (______) ____________________

Office Contact: ____________________ Title: ____________________

Referring MD assessment: ☐Excellent ☐Good ☐Marginal ☐Unacceptable

PATIENT INFORMATION

Cause of ESRD: ____________________ Height: ________cm Weight: ________kg BMI: ______

Treatment Modality: ☐HD ☐CAPD ☐CCPD ☐CKD 1st Day of Chronic Dialysis: ____________

Dialysis Schedule: ☐MWF ☐TTS Shift: ☐1st ☐2nd ☐3rd

Previous Transplant? ☐No ☐Yes: When? ____________ Where? ____________

Patient listed (or evaluated) at another transplant center? ☐No ☐Yes: Where? ____________

Smoker: ☐Yes ☐No Potential Living Donors: ☐Yes ☐No