# Kidney and/or Pancreas Referral Form

PH: (318) 212-8140 FX: (318) 212-8511

| TYPE OF TRANSPLANT | | |
|---|---|---|
| ☐ Kidney Transplant | ☐ Pancreas Transplant | ☐ Kidney/Pancreas Transplant |
| Has the patient been referred to our Transplant Center previously for an organ transplant ☐ yes ☐ no if so, when:_____ | | |

| PATIENT INFORMATION | Last Name: | First Name: | MI: |
|---|---|---|---|
| Address: Apt#: | | City: State: | Zip: |
| Home Phone: | Alternate Phone: | SSN: | |
| Sex: ☐ Male ☐ Female ☐ Other | Marital Status: | Driver Lic #: | |
| Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian or Alaska Native ☐ Other: | | | |
| Speaks English: ☐ Yes ☐ No | Language Preference: | Hearing impaired: ☐ Yes ☐ No | Vision impaired: ☐ Yes ☐ No |
| Employed ☐ Yes ☐ No | Employer: | Phone: | |
| Address | City: State: | Zip: | |

| EMERGENCY CONTACT | | | |
|---|---|---|---|
| Name: | Phone# | Relationship | |
| Address: Apt#: | City: State: | Zip: | |
| Home Phone: | Alternate Phone: | | |

| DIALYSIS INFORMATION | Referring Physician: | Phone: | Fax: |
|---|---|---|---|
| Dialysis Center | Phone: | Fax: | |
| Dialysis Start date: | Type of Access: | Social worker: | |
| Type of Dialysis: ☐ Hemo ☐ Home Hemo ☐ CAPD ☐ APD ☐ Not yet on dialysis | Schedule: ☐ M/W/F ☐ T/T/S ☐ AM ☐ PM ☐ Nocturnal | | |

| MEDICAL INFORMATION | | | |
|---|---|---|---|
| Cause of organ failure: | Weight: Height: | Date taken: | |
| Allergies: | Diabetes: ☐ Yes ☐ No | Age of onset: | |
| Hep C: ☐ Negative ☐ Positive | Hep B Antigen: ☐ Negative ☐ Positive | HIV: ☐ Negative ☐ Positive | |
| Limitations: ☐ walker ☐ wheelchair ☐ cane ☐ other_____ | Family support: ☐ Yes ☐ No | | |

| INSURANCE INFORMATION | | |
|---|---|---|
| Primary Policy Holder's Name: | DOB: | SSN: |
| Insurance Company: | Customer Service #: | |
| Policy / ID #: | Group #: | |

| IF ANSWERING YES TO ANY QUESTION BELOW PLEASE PROVIDE DOCUMENTATION | | | | |
|---|---|---|---|---|
| History or current cancer | ☐ Yes ☐ No | | History or current substance abuse | ☐ Yes ☐ No |
| Active infections | ☐ Yes ☐ No | | Psychological/social limitations | ☐ Yes ☐ No |
| Superior Vena Cava Syndrome | ☐ Yes ☐ No | | Compliance | ☐ Yes ☐ No |
| CAD, PVD, or CVA disease | ☐ Yes ☐ No | | Hypercoagulable state | ☐ Yes ☐ No |

| REQUIRED DOCUMENTS (Please provide a copy of the following required documents) FAX TO: (318) 212-4503 | | |
|---|---|---|
| ☐ Recent history and physical | ☐ ESRD 2728 form | ☐ Social history |
| ☐ Care plan | ☐ Treatment summary (3 months) | ☐ Insurance cards |

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