JOHN C. MCDONALD
REGIONAL TRANSPLANT CENTER

Kidney and/or Pancreas Referral Form

Montana Laney, CCMA, Referral Intake Coordinator
PH: (318) 212-8140 FX: (318) 212-8511

TYPE OF TRANSPLANT		
☐ Kidney Transplant	☐ Pancreas Transplant	☐ Kidney/Pancreas
Has the patient been referred to our Transplant Center previously for an organ transplant: Yes	if so, when:	

PATIENT INFORMATION	Last Name:	First Name:	MI:
Address:	Apt#:	City:	State: Zip:
Home Phone:	Alternate Phone:	SSN:	
Sex: Male	Marital Status:	Driver Lic #:	
Race: Caucasian	If Other:		
Speaks English: Yes	Language Preference:	Hearing impai Yes	Vision impaired: Yes
Employed: Yes	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	Schedule: M/W/F AM		

MEDICAL INFORMATION			
Cause of organ failure:	Weight:	Height:	Date taken:
Allergies:	Diabetes: Yes	Age of onset:	
Hep C: Positive	Hep B Antigen: Positive	HIV: Positive	
Limitations: None	other:	Family support: Yes	

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	History or current substance abuse	Yes
Active infections	Yes	Psychological/social limitations	Yes
Superior Vena Cava Syndrome	Yes	Compliance Issues	Yes
CAD, PVD, or CVA disease	Yes	Hypercoagulable state	Yes

REQUIRED DOCUMENTS (Please provide a copy of the following required documents) FAX TO: (318) 212-8511		
☐ Recent history and physical	☐ ESRD 2728 form	☐ Social history
☐ Care plan	☐ Treatment summary (3 months)	☐ Insurance cards

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