



Kidney, Kidney-Pancreas Transplant Physician Referral Form

This referral form is to request a **pre-transplant evaluation** for potential kidney or kidney-pancreas transplant.

If this referral is for post-transplant follow-up, please call 614-293-8746 for assistance.

To speak with a pancreas transplant coordinator, call **800-293-8965**.

Please fill out this form completely, include any clinical documentation relevant to this referral, and fax all documents to **614-293-6710**.

Mail any additional imaging CDs and/or documentation to: **300 W. 10th Ave., 11th Floor, Columbus, OH 43210**.

Clinical Documentation included

(Examples include: insurance cards, imaging, lab work, office procedures, office notes, etc.)

Patient Information:

First Name:

Middle Name:

Last Name:

Gender:

Marital Status:

Last 4-digits SSN#:

Date of Birth (mm/dd/yyyy):

BMI:

Primary Phone:

Email: (required for virtual education)

Primary Insurance:

Secondary Insurance:

Street Address:

City:

State:

Zip:

County:

Details:

Primary Cause of Kidney Failure:

Height:

Weight:

Dialysis start date (current center): If no, patient's GFR?

Patient on dialysis? **Yes** **No**

Has a 2728 Form been completed? **Yes** **No** **If complete, please include with this referral.**

Dialysis Center:

Dialysis Phone:

Dialysis Fax:

Any issues with patient adherence to treatment? **Yes** **No**

Does patient agree to receive blood products? **Yes** **No**

Is the patient aware of being referred to see the transplant specialist? **Yes** **No**

Form will be returned if incomplete information is provided.

Patient will be contacted regarding scheduling of an appointment after complete referral is received.

Person Completing Form:



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Page 2 of 2

Patient Name:

Date:

Medical History:

	Yes	No	Date	Diagnosis	Comments
Cancer					
HIV					
Cardiovascular Disease					
Diabetes					
Pulmonary Disease					
Active Untreated Systemic Infection					
Non-Healing Wound					
Substance Use Disorder					
Psychiatric Illness					

Required for Initial Referral:

Below documents are required for initial referral:

- 1) Medicare 2728 form, if on dialysis
- 2) Demographics sheet with current insurance information (or clear copy of insurance card – front and back)
- 3) Current history and physical within the past 12 months
- 4) Missed or Shortened Treatment reports for the past 6 months, if applicable

If available, to expedite referral, please provide below information:

- 1) Recent stress test (less than one year ago)
- 2) Recent cardiac echo (less than one year ago)
- 3) Recent labs
- 4) Psychosocial evaluation

Referring Provider Information:

Provider First Name:

Provider Last Name:

Street Address:

City:

State:

Zip:

Phone:

Extension:

Fax:

Physician Signature: _____ Date: _____