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:**

Patient on dialysis? ◯ **Yes** ◯ **No** | **Dialysis start date (current center):** | **If no, patient's GFR?**

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 receiv e 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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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:_____