Charles O. Strickler Transplant Center
Kidney Transplant Referral Form

Fax to: Pauline Coleman (Please Print) **Fax #: 434-924-8774**

❑ **Kidney Only** ❑ **Pancreas Only** ❑ **Kidney and Pancreas** ❑ **Other Eval/Procedure**___________________________

Today's date:	Name of Practice:		
Address:		Phone: ( )	Fax: ( )
Referring Provider:		**Contact Person:**	
PCP (if different from referring):			

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex ❑ M ❑ F	Birth Date / /	Soc. Security Number _ _ _ - _ _ - _ _ _ _

Street address:			PO Box:	Home phone: ( )
City:	State:	ZIP Code:	Work phone: ( )	Cell phone: ( )

Height:	Weight:	Dry Weight:	BMI:	Primary Language Spoken: Interpreter needed: ❑ Y ❑ N

Race:	Ethnicity:	Marital Status:	
Name of Emergency Contact:	Relation to Patient:	Primary phone:	Cell phone:

INSURANCE INFORMATION <u>(INCLUDE COPY OF INSURANCE CARD, BOTH FRONT AND BACK)</u>

Is this patient covered by insurance?	❑ Yes	❑ No	
Please indicate primary Insurance:			

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

KIDNEY DIAGNOSIS INFORMATION (Please Check All That Apply)

❑ HTN ❑ DM (Type I or Type II) ❑ PCKD ❑ FSGS ❑ MPGN ❑ PBC ❑ SLE ❑ Other ________________

Dialysis Status ❑ Yes-Hemodialysis ❑ Yes- Peritoneal dialysis ❑ No

Dialysis Unit ___________________________________ Dialysis Start Date __________________

Phone #___________________________________ Dialysis Days M Tu W Th F Sa or Home Nocturnal

PLEASE INCLUDE THE FOLLOWING RECORDS IF AVAILABLE

❑ Most Recent Medication List Attached
❑ Most Recent H&P Attached
❑ Most Recent Progress Note attached
❑ Most Recent Problem List attached
❑ Most Recent Lab Results attached
❑ TB Test Results attached (if currently on Dialysis)

☐ **End Stage Renal Disease Medical Evidence Report- CMS 2728 if patient is on dialysis**

<u>OR</u>

☐ **GFR of 20 or less result (that has been adjusted for race if needed)**

- **<u>NOTE:</u> Result must include: include name of lab, date of result)**

PO Box 800265, Charlottesville, VA 22908 **Phone: 434-924-8604 (opt 3, 1) or 1-800-543-8814**