

# Kidney, Kidney-Pancreas Transplant Physician Referral Form



Inpatient transfer request? Yes  No

If urgent consultation is needed, please call **614-293-4444**.

Updated 12/6/2021

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**.

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

**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:  Country:

## Details:

Primary Cause of Kidney Failure:  Height:  Weight:

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

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

## Referring Provider Information:

Provider First Name:  Provider Last Name:  NPI Number:

Street Address:  City:  State:

Zip:  Phone:  Extension:  Fax:

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Page 2 of 2

Patient Name:

Date:

## Medical History:

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	Yes	No	Date	Diagnosis	Comments
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HIV	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cardiovascular Disease	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pulmonary Disease	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Active Untreated Systemic Infection	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Non-Healing Wound	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Substance Use Disorder	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Psychiatric Illness	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Required for Initial Referral:

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### Below documents are required for initial referral:

- 1) Medicare 2728 form, if on dialysis
- 2) Copy of insurance card (front and back) and photo ID
- 3) Current history and physical within the past 12 months

### 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

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**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: