Kidney and/or Pancreas Referral Form

PH: (318) 212-8140 FX: (318) 212-8511

TYPE OF TRANSPLANT		
☐ Kidney Transplant	☐ Pancreas Transplant	☐ Kidney/Pancreas Transplant
Has the patient been referred to our Transplant Center previously for an organ transplant ☐ yes ☐ no if so, when:_____		

PATIENT INFORMATION	Last Name:	First Name:	MI:
Address: Apt#:		City: State:	Zip:
Home Phone:	Alternate Phone:	SSN:	
Sex: ☐ Male ☐ Female ☐ Other	Marital Status:	Driver Lic #:	
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian or Alaska Native ☐ Other:			
Speaks English: ☐ Yes ☐ No	Language Preference:	Hearing impaired: ☐ Yes ☐ No	Vision impaired: ☐ Yes ☐ No
Employed ☐ Yes ☐ No	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 ☐ Home Hemo ☐ CAPD ☐ APD ☐ Not yet on dialysis	Schedule: ☐ M/W/F ☐ T/T/S ☐ AM ☐ PM ☐ Nocturnal		

MEDICAL INFORMATION			
Cause of organ failure:	Weight: Height:	Date taken:	
Allergies:	Diabetes: ☐ Yes ☐ No	Age of onset:	
Hep C: ☐ Negative ☐ Positive	Hep B Antigen: ☐ Negative ☐ Positive	HIV: ☐ Negative ☐ Positive	
Limitations: ☐ walker ☐ wheelchair ☐ cane ☐ other_____	Family support: ☐ Yes ☐ No		

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 ☐ No		History or current substance abuse	☐ Yes ☐ No
Active infections	☐ Yes ☐ No		Psychological/social limitations	☐ Yes ☐ No
Superior Vena Cava Syndrome	☐ Yes ☐ No		Compliance	☐ Yes ☐ No
CAD, PVD, or CVA disease	☐ Yes ☐ No		Hypercoagulable state	☐ Yes ☐ No

REQUIRED DOCUMENTS (Please provide a copy of the following required documents) FAX TO: (318) 212-4503		
☐ Recent history and physical	☐ ESRD 2728 form	☐ Social history
☐ Care plan	☐ Treatment summary (3 months)	☐ Insurance cards

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