Patient Referral for Kidney and/or Pancreas Transplantation

Referring Physician: ____

Tel#:___________________________________ Fax: ___________________________

Evaluate for: ___ Kidney ___ Pancreas ___ Kidney and Pancreas

Patient Name:_________________________________ DOB: _______________

Tel#:___________________________ E-mail address____

Address____

____

Insurance: ____

On Dialysis __Y __N Dialysis Start Date _____________ Unit: __________________________

Reason for ESRD: ________________________________

Biopsy: ____________________________________Where/when: _________________________________

Listed at another center: _________________________Where/when: ________________________________

Previous transplant _____________________________Where/when: ________________________________

Comments: ____

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Please fax this Referral Form, patient's medical insurance card, and a copy of the patient's medical records to 551-996-0826

Our office will contact the patient for an initial evaluation and education session. Thereafter, we will advise you of our findings regarding the patient's eligibility for a potential transplant as well as the patient's status throughout the process.

Thank you for this referral

Please call us if you have any questions: 551.996.2608