



The UNIVERSITY of OKLAHOMA

920 N.E. 13<sup>th</sup> St. | Ste. 2000 | Oklahoma City, OK 73104

Main Clinic: (572) 244-0060 | Fax: (572) 244-9836 | Transplant.Schedulers@OUHealth.com

## Kidney / Pancreas Transplant Referral

Are you referring this patient for a  Kidney OR  Pancreas Transplant Evaluation?

Date: \_\_\_\_\_

This is a non-English speaking patient:  Yes  No

Patient's Name: \_\_\_\_\_

Male / Female

SSN: \_\_\_\_\_

Age / DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary ESRD Diagnosis: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Previous Transplant:  Yes  No

Date: \_\_\_\_\_

Dialysis Center: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone Number/Ext: \_\_\_\_\_

Dialysis Day: **M T W Th F Sat** Time: \_\_\_\_\_ Type: \_\_\_\_\_

1st Treatment Date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Organ:  Kidney  Pancreas  Simultaneous Kidney/Pancreas

Potential Living Donor?  Yes  No

Problems: \_\_\_\_\_

Interval History: \_\_\_\_\_

**Please send the following information with the referral form (if available):**

- |   |   |
|---|---|
| <input type="checkbox"/> Demographics                       | <input type="checkbox"/> Medication List                              |
| <input type="checkbox"/> Discharge Summaries                | <input type="checkbox"/> Office / Clinic / Progress Notes             |
| <input type="checkbox"/> Echocardiogram/Stress Echo         | <input type="checkbox"/> Operative Reports                            |
| <input type="checkbox"/> EKG (within 6 months)              | <input type="checkbox"/> Colonoscopy                                  |
| <input type="checkbox"/> Gynecological Evaluation (females) | <input type="checkbox"/> Pathology Reports                            |
| <input type="checkbox"/> H & P                              | <input type="checkbox"/> PPD Test                                     |
| <input type="checkbox"/> Insurance Info (card front/back)   | <input type="checkbox"/> PSA (males)                                  |
| <input type="checkbox"/> Kidney Biopsies                    | <input type="checkbox"/> Ultrasounds                                  |
| <input type="checkbox"/> Labs (most recent)                 | <input type="checkbox"/> CMS Form 2728                                |
| <input type="checkbox"/> Mammogram (females)                | <input type="checkbox"/> Radiology & Other Diagnostic Imaging Reports |

**If patient is on dialysis, please provide:**

- Psychological History
- Last Flu Shot
- Hep B Immunization Documentation
- Last Pneumo Vax Shot



**REFERRING PHYSICIAN:**

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Printed Name	NPI #	Email
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Mailing Address	City	State	Zip
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Office Phone	Office Fax
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