OU Health
Transplant Institute

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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):

- ☐ Demographics
- ☐ Discharge Summaries
- ☐ Echocardiogram/Stress Echo
- ☐ EKG (within 6 months)
- ☐ Gynecological Evaluation (females)
- ☐ H & P
- ☐ Insurance Info (card front/back)
- ☐ Kidney Biopsies
- ☐ Labs (most recent)
- ☐ Mammogram (females)
- ☐ Medication List
- ☐ Office / Clinic / Progress Notes
- ☐ Operative Reports
- ☐ Colonoscopy
- ☐ Pathology Reports
- ☐ PPD Test
- ☐ PSA (males)
- ☐ Ultrasounds
- ☐ CMS Form 2728
- ☐ 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:

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