UMC UNIVERSITY MEDICAL CENTER
TRANSPLANT CENTER

TRANSPLANT REFERRAL FORM

Referral will be delayed if all items below are not included in the referral:

Referred for: ☐ Kidney ☐ Pancreas ☐ Kidney/Pancreas

Diabetic: Yes ☐ No ☐ Type 1 ☐ Type 2 ☐

MUST include/fax the following information:

Date: _____

- ☐ History and Physical (Within 1 Year)
- ☐ Medication List (Current & Active)
- ☐ Current Labs (Include Renal Function Panel)
- ☐ Legible Copies of ID and ALL insurance cards (Including VA, Medicare, Medicaid etc.)
- ☐ ALL Health Maintenance Testing (See Attached List)
- ☐ Completed Post Transplant Care Support Form
- ☐ Completed Transplant Candidate Questionnaire
- ☐ CMS 2728 Form
- ☐ Immunization Records
- ☐ Completed/Signed PHI consent

****Complete every line. If it does not apply put "N/A"****

Legal Name: Last_____ **First**_____ **Preferred Name:**_____

Male ☐ Female ☐ Height:_____ **Weight:**_____ **BMI:**_____

Address:_____ **City:**_____ **State:**____ **Zip:**_____

Phone: Cell:_____ **Home:**_____ **Email:**_____

Primary Language:☐ English ☐Spanish ☐Other: _____ **Date of Birth:** _____

Patient Race:_____ **Ethnicity:** _____ **Social Security Number:**_____

Current Insurance(s):_____

Referring Physician:_____ **Phone:**_____ **Fax:**_____

Dialysis Unit: _____ **Phone:** _____ **Fax:** _____

Dialysis Location/Address:_____

Social Worker/Case Manager: _____ **Email :** _____

Does the patient have a potential living donor? ☐Yes ☐No

Patient has established care with PCP? (Has been seen within the past year) ☐Yes ☐No

PCP Name: _____ **Phone:** _____ **Fax:**_____

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Fax to 702-383-1876

UMC Center for Transplantation Main Line: 702-383-2224

TransplantReferrals@umcsn.com

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