OU Health
Transplant Institute

920 NE 13th Street | Oklahoma City, OK 73104
Phone (405) 271-7498 | Toll Free (877) 817-6911 | Fax (405) 271-1772

# KIDNEY TRANSPLANT REFERRAL
# PANCREAS TRANSPLANT REFERRAL

***Are you referring this patient for a*** ☐ ***Kidney OR*** ☐ ***Pancreas Transplant Evaluation?*** ☐ ***YES*** ☐ ***NO***

**DATE:** _____ **This is a Non-English speaking patient:** ☐ **YES** ☐ **NO**

**Patient Name:** _____ **SSN:** _____ **DOB:** _____

**Age:** _____ **Sex:** _____ **Race:** _____

**Current Address:** _____

**City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

**Primary ESRD diagnosis:**

**Height:** _____ **Weight:** _____ **BMI:** _____ **Previous Transplant:** ☐ **YES** ☐ **NO** **Date:** _____

**Dialysis Center:** _____ **Phone:** _____ **Fax:** _____

**Dialysis Ctr Address:** _____ **City/State:** _____ **Zip:** _____

**Contact Name:** _____ **Phone # / 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)

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

- [ ] Kidney biopsies
- [ ] Labs (most recent)
- [ ] Mammogram (females)
- [ ] Medication list
- [ ] Office/clinic/progress notes
- [ ] Operative reports
- [ ] Colonoscopy
- [ ] Psychosocial History
- [ ] Last Flu shot
- [ ] Pathology reports
- [ ] PPD test
- [ ] PSA (males)
- [ ] Ultrasounds
- [ ] CMS Form 2728
- [ ] Radiology & other diagnostic imaging reports
- [ ] Hep B Immunization documentation
- [ ] Last Pneumo Vax shot

**REFERRING PHYSICIAN:**

**NPI**

Printed Name Email

Mailing Address City State Zip

Phone Fax