Kidney/Pancreas Transplant Referral

1120 15th St., AD-3401 Augusta, GA 30912 wellstar.org **P** (706) 721-2888 **F** (706) 721-6271



REQUIRED DOCUMENTS FOR PROCESSING ☐ Insurance Cards (legible copy, front and back) ☐ H&P w	ithin the past 12 months	☐ <u>If on dialysis:</u>	
☐ Driver's License or State Issued ID ☐ Recent	Medication List	☐ Form 2728	
PATIENT INFORMATION Last Name: First Name: Date of Birth: SSN: Address: City: Home Phone: Mobile	Sta	ite: Zip:	
REFERRAL INFORMATION Referring Physician: Dialysis Center: Initial Dialysis Date: Hemodialysis Schedule: Mon-Wed-Fri Tu-Thu-Sat Form Completed By:	Type of dialysis:	Phone: HD PD Home Other:	е НС
INSURANCE INFORMATION Medicare Medicaid VA Comprimary Insurance: Secondary/Tertiary Insurance: Estimated years of employment:	Prescription Plo		
MEDICAL INFORMATION Cause of renal failure (primary diagnosis):	Weight (kg): Does the patient e Diabetes Previous transpla Active infectious (HIV, Hepatitis B Autoimmune dise Heart attack, stre	xhibit or have a history of: Int If yes, specify disease or C, ongoing infection) ease oke, stent in heart or bypass	