Kidney/Pancreas Transplant Referral

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Wellstar
AFFILIATED WITH MEDICAL COLLEGE OF GEORGIA

REQUIRED DOCUMENTS FOR PROCESSING

☐ **Insurance Cards** *(legible copy, front and back)* ☐ **H&P within the past 12 months** ☐ ***If on dialysis:***

☐ **Driver's License or State Issued ID** ☐ **Recent Medication List** ☐ **Form 2728**

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____

Dialysis Center: _____ Phone: _____

Initial Dialysis Date: _____ Type of dialysis: _____ HD PD Home HD

Hemodialysis Schedule: ☐ Mon-Wed-Fri ☐ Tu-Thu-Sat ☐ Nocturnal Other: _____

Form Completed By: _____ Date: _____ Phone: _____

INSURANCE INFORMATION

☐ Medicare ☐ Medicaid ☐ VA ☐ Commercial

Primary Insurance: _____ Prescription Plan: _____

Secondary/Tertiary Insurance: _____

Estimated years of employment: _____ ☐ Working ☐ Not Working ☐ Retired

MEDICAL INFORMATION

Cause of renal failure (primary diagnosis): _____

Measured, without shoes Height (cm): _____ Weight (kg): _____ BMI: _____

Patient in evaluation or listed at another transplant center

If yes, where _____

Patient exhibits compliance concerns

If yes, specify _____

Remarks or reservations regarding referral:

Does the patient exhibit or have a history of:

☐ Diabetes
☐ Previous transplant *If yes, specify* _____
☐ Active infectious disease
☐ (HIV, Hepatitis B or C, ongoing infection)
☐ Autoimmune disease
☐ Heart attack, stroke, stent in heart or bypass
☐ Malignancy *If yes, specify* _____
☐ Sensory deficit (blindness, hearing loss)
☐ Severe pulmonary disease
☐ Active alcohol or substance abuse
☐ Smoking

FOR WELLSTAR MCG HEALTH MEDICAL CENTER TRANSPLANT PROGRAM USE

Received by: _____ Date/Time: _____