TRANSPLANT PROGRAM REFERRAL FORM

☐ **Kidney** ☐ **Kidney/Pancreas** ☐ **Pancreas**

Patient Information:		
Name:	SSN:	DOB:
Mailing Address:	City / State / Zip:	
Primary Phone:	Emergency Contact Name:	
Alternative Phone:	Emergency Contact Telephone:	
Email Address:	Preferred Language:	
Height: Weight: BMI:	Gender:	

Insurance	Subscriber	Policy/Member ID #	Authorization #	Eff. Date

Primary MD:	Phone:	Fax:
Referring MD:	Phone:	Fax:

Etiology of Renal Failure:	Social Worker:
Dialysis Unit Name:	Dialysis Type: ☐ HEMO ☐CAPD ☐ CCPD ☐HOME HEMO
Phone:	Dialysis Schedule: ☐ M/W/F ☐T/T/S ☐ _____
Fax:	

Medical History	Other Pertinent Medical/Surgical History
☐ Coronary Artery Disease	
☐ Cardiac Catheterization	
☐ Peripheral Vascular Disease	
☐ Cancer (Type & Year)	
☐ Substance Abuse (Type & Year)	
☐ Psychological/Social Limitations (Describe)	
☐ Diabetes Mellitus	

Thank you for your referral to the Comprehensive Transplant Center.

To expedite the referral process, please send all required patient records listed below and any recent studies from the requested list. When all required records have been received and reviewed, the patient will receive an appointment, welcome letter, and transplant program information.

Required Patient Records:
☐ Completed Referral Form ☐ Insurance Cards (Clear copy of front and back) ☐ Photo I.D./Driver's License ☐ 2728 Form ☐ Recent History & Physical (H&P- MD Consult Note) ☐ Recent Laboratory Studies ☐ Proof of COVID-19 Vaccine
Requested Patient Records (if completed):
☐ Recent Hospital Discharge Summary/Clinic Notes ☐ Recent Diagnostic Studies ☐ Chest X-Ray and other radiological reports ☐ EKG ☐ Cardiac Stress Test/Cardiac Catheterization ☐ Echocardiogram ☐ Colonoscopy ☐ Renal Biopsy ☐ Pap Smear/Mammogram ☐ ABO Blood Type

Submit Records:
E-MAIL: KidneyReferral@cshs.org OR FAX / MAIL TO: Fax: (310) 423-7898 Office: (310) 423-2641 Mail: Kidney/Pancreas Transplant Program Comprehensive Transplant Center 8900 Beverly Blvd. 2nd Floor Los Angeles, CA 90048