



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: <input type="checkbox"/> HEMO <input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> HOME HEMO
Phone:	Dialysis Schedule: <input type="checkbox"/> M/W/F <input type="checkbox"/> T/T/S <input type="checkbox"/> _____
Fax:	

Medical History	Other Pertinent Medical/Surgical History
<input type="checkbox"/> Coronary Artery Disease	
<input type="checkbox"/> Cardiac Catheterization	
<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Cancer (Type & Year)	
<input type="checkbox"/> Substance Abuse (Type & Year)	
<input type="checkbox"/> Psychological/Social Limitations (Describe)	
<input type="checkbox"/> 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:
<ul style="list-style-type: none"><input type="checkbox"/> Completed Referral Form<input type="checkbox"/> Insurance Cards (Clear copy of front and back)<input type="checkbox"/> Photo I.D./Driver's License<input type="checkbox"/> 2728 Form<input type="checkbox"/> Recent History & Physical (H&P- MD Consult Note)<input type="checkbox"/> Recent Laboratory Studies
Requested Patient Records (if completed):
<ul style="list-style-type: none"><input type="checkbox"/> Recent Hospital Discharge Summary/Clinic Notes<input type="checkbox"/> Recent Diagnostic Studies<input type="checkbox"/> Chest X-Ray and other radiological reports<input type="checkbox"/> EKG<input type="checkbox"/> Cardiac Stress Test/Cardiac Catheterization<input type="checkbox"/> Echocardiogram<input type="checkbox"/> Colonoscopy<input type="checkbox"/> Renal Biopsy<input type="checkbox"/> Pap Smear/Mammogram<input type="checkbox"/> ABO Blood Type

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