Referral for Kidney Transplant Evaluation

Date:

PATIENT INFORMATION

FIRST NAME: LAST NAME: DOB

Race: Height: Weight:

SSN (for transplant regulatory purposes)

PATIENT/GUARDIAN CONTACT INFORMATION

Parent/guardian #1

Name Relationship:

Address Phone:

Email: Marital Status:

Are you the custodial parent? ◯ Yes ◯ No

Parent/guardian #2

Name Relationship:

Address Phone:

Email: Marital Status:

Are you a custodial parent? ◯ Yes ◯ No

Does the patient live with both parents in same household? ◯ Yes

◯ No If no, where does the child primarily reside?

INSURANCE INFORMATION

Name of Insurance	Insurance Carrier	Name of insured

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REFERRAL INFORMATION

Referring MD	Location	MD Contact Number

Clinical Summary *(Please include underlying diagnosis, rate of CKD progression, any noteworthy testing (genetic testing), significant outstanding medical involvement, psychosocial concerns)*

History/Current Concerns

Recurrent infections: ◯ yes (describe, please include known organisms) ◯ No

History/Current Concerns (Continued)

- ☐ Previous vasodilator use
- ☐ Reactive airway disease
- ☐ Pulmonary hypertension
- ☐ Prematurity/NICU
- ☐ Dialysis (if so, modality)
- ☐ Chronic oxygen requirement
- ☐ Clotting history
- ☐ Hypoplasia

Dialysis Center Name and Contact:

☐ History of central line placement (please list all central lines and location of placement below, includes PICC line)

Other specialties involved

☐ Urology
☐ Gastroenterology
☐ Hematology
☐ Neurology
☐ Feeding team/Speech
☐ Endocrine
☐ Cardiology
☐ Pulmonary
☐ ENT
☐ Psychology
☐ Orthopedics
☐ Other: please list

RECENT CLINICAL DOCUMENTATION REQUIRED

Recent hospitalizations and discharge diagnosis (*attach discharge summary*)

☐ Last Nephrology note *(attach copy)*
☐ Immunization History *(attach copy)*
☐ Labs *(attach copy)*

Labs last 3 months:

☐ Renal Profile
☐ GFR
☐ CBC
☐ Viral studies

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RECENT CLINICAL DOCUMENTATION REQUIRED (CONT)

Testing/ Imaging *(attach copy)*

- ☐ ECHO/EKG
- ☐ Renal ultrasounds
- ☐ Local Urology testing (Urodynamics/VCUG) and last Urology clinic note
- ☐ Access imaging

Relevant Operative notes (i.e.: line placements, removals, ostomies, trachs, other tx) *(attach Copy)*

Any additional relevant information

Please fill out below information stating who will be the contact person for patient updates, labs, records, etc.

Name

Title

Email

Phone

Fax