KIDNEY TRANSPLANT REFERRAL FORM

University of Tennessee Medical Center
Center for Transplant Services
1928 Alcoa Highway Ste B324 Knoxville, TN 37920
Phone: 865-305-9236 Fax: 865-305-6117

Fax forms and requested materials to 865-305-6117

Patient Demographics (please attach demographic sheet)

Last Name First Name Middle Initial Date of Birth Gender

Mailing Address Social Security Number

City State Zip (____)_____ Best Contact Phone Number

Dialysis Information: O Not on Dialysis O Dialysis Start Date_____ O PD O Hemo O HHD O MWF O TTS

Referring Nephrologist: _____ Office Contact Name: _____

Dialysis Unit Name: _____ Phone ( )_____ Fax ( )_____

Address: _____

Insurance (please attach front and back of insurance cards, including prescription cards)

Primary Insurance Name: _____ Policy ID: _____ Group: _____

Secondary Insurance Name: _____ Policy ID: _____ Group: _____

Policy Holders Name: _____

Pre-Screen Information

Cause of ESRD: _____

Age: _____ Height: _____ (in) Weight: _____ (kg) BMI: _____ EDW: _____ A1C: _____ PO4: _____

Please include the following documentation with the referral:

O Demographics O 2728/ Recent GFR O Copy of Insurance Cards O Medication List O Recent H & P
O Recent Labs O Recent Plan of Care/ Psychosocial Assessment O COVID Vaccine Card

KIDNEY TRANSPLANT REFERRAL FORM
PRE-SCREEN QUESTIONNAIRE

University of Tennessee Medical Center
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Phone: 865-305-9236 Fax: 865-305-6117

Pt Name: _____

Cause of ESRD: _____

Does the patient use oxygen? O Yes O No If yes, when, and how long? _____

Does the patient currently smoke? O Yes O No If so, how many daily and for how many years? _____

Diagnosis of COPD? O Yes O No If yes, please describe: _____

History of Cancer? O Yes O No If yes, when and what type? _____

Heart problems/history? O Yes O No If yes please include cardiac documentation

History of Hepatitis B/C? O Yes O No If yes, has the patient received treatment? _____

History of HIV? O Yes O No If yes, please describe: _____

Any chronic/open wounds? O Yes O No If yes, where: _____

Substance Abuse Concerns: O Yes O No If yes, please describe: _____

Psychosocial Concerns: O Yes O No If yes, please describe: _____

_____

Support Concerns: O Yes O No If yes, please describe: _____

_____

Is patient receiving AKF Assistance? O Yes O No If yes, please describe: _____

Is patient LIS eligible? O Yes O No If yes, please describe: _____

Does the patient use any community services such as Choices or Home Care Services? O Yes O No

If so, explain: _____

Does the patient use any assistive device? O Yes O No If so, explain: _____

Patient Compliance: O Excellent O Good O Fair O Poor Please describe: _____

Number of missed treatments (not hospital related) in the last 60 days: _____

Number of shortened treatments in the last 60 days: _____

Employment Status: O Full Time O Part Time O Not Working/ Retired

Functional Status: O Good O Fair O Poor Comments: _____