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 form and requested materials to 865-305-6117

Patient Demographics (please attach demographic sheet)

Last Name First Name Middle Initial Date of Birth

Mailing Address Gender Race Social Security Number

City State Zip Phone Number

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

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

Address: _____

Attending Nephrologist: _____ Office Contact: _____

Insurance (please attach front and back of insurance cards)

Primary Insurance Name: _____ Policy ID: _____ Group: _____
Policy Holders Name: _____
Insurance Phone Number: _____

Secondary Insurance Name: _____ Policy ID: _____ Group: _____
Policy Holders Name: _____
Insurance Phone Number: _____
Is patient receiving AKF Assistance? ( ) Yes ( ) No Is patient LIS eligible? ( ) Yes ( ) No

Pre-Screen Information **Cause of ESRD:**_____

Age: _____ Height: _____ (inches) Weight: _____ (kg) BMI: _____ EDW: _____

Albumin _____ Phosphorus _____ Potassium_____ Calcium _____ A1C _____

Does the patient use oxygen? ( ) Yes ( ) No If yes, when and how long? _____
History of Malignancy? ( ) Yes ( ) No If yes, when and what type? _____
Does the patient have CAD? ( ) Yes ( ) No If yes please include cardiac documentation
Does the patient have Hepatitis? ( ) Yes ( ) No If yes, has the patient received treatment? Include records
Does the patient have HIV? ( ) Yes ( ) No
Does the patient currently have an open wound? ( ) Yes ( ) No If yes, where: _____

Substance Abuse Concerns: ( ) Yes ( ) No If yes, please describe: _____
Psychosocial Concerns: ( ) Yes ( ) No If yes, please describe: _____
Compliance Concerns: ( ) Yes ( ) No If yes, please describe: _____
Number of missed treatments (not hospital related) in the last 60 days: _____ Shortened treatments last 60 days: _____:
_____
Does the patient currently smoke? ( ) Yes ( ) No If so how many daily and for how long?_____

PLEASE ATTACH THE FOLLOWING ITEMS PRIOR TO FORWARDING THIS REFERRAL:

-Demographics Sheet
-Insurance Cards and Prescription Cards (front and back)
-Plan of Care/ Psychosocial Evaluation (most recent)
-History and Physical
-Medication List
-2728
-Labs (most recent)