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: _____