Patient Label

St. Joseph Kidney Transplant Center

NEW REFERRAL INTAKE FORM

Referred by: ☐ Nephrologist ☐ PCP ☐ Case Manager ☐ Social Worker ☐ R.N. ☐ Self ☐ Other: ____

Date of Referral:

Name of Caller: ☐ Patient Caller Name: ____ Position: ____ Phone #: ____

Patient Name: ____ DOB: ____ SSN: ____ ☐ M ☐ F

Address: ____ City: ____ State: ____ Zip: ____

Telephone: Home: ( ) - ____ Work: ( ) - ____

Other Contacts: ____ ____

Primary Language: Race: Marital Status:

DIALYSIS UNIT:		Dialysis Type: ☐ Pre ☐ PD ☐ Hemo	Dialysis Day: ☐ MWF ☐ TTS	Dialysis Time:
Address:		City:	State:	Zip:
Telephone #:	Fax #:	Dialysis Start Date:		

REFERRING MD:		Specialty:	
Address:	City:	State:	Zip:
Telephone #:	Fax #:	Pager #:	

PCP:		Specialty:	
Address:	City:	State:	Zip:
Telephone #:	Fax #:	Pager #:	

OTHER (CM):		Specialty:	
Address:	City:	State:	Zip:
Telephone #:	Fax #:	Pager #:	

Patient information to be faxed to 714.744.8753:

- Demographic sheet
- Insurance cards (copy of front and back)
- History and Physical
- Current medications
- Most current laboratory results
- Any diagnostic test - EKG, CXR, PPD, ultrasounds
- Psycho-social evaluation
- Form 2728