

UCI Health

NEW TRANSPLANT PATIENT REFERRAL

(Please check all that apply)

- Kidney Transplant
 Kidney/Pancreas Transplant
 Pancreas Transplant

A COMPLETE REFERRAL INCLUDES THE FOLLOWING:

History & Physical that states cause of ESRD, CMS-2728 Form, Medication List, Most Recent Labs

PLEASE FILL OUT COMPLETELY AND FAX TO 888-972-2110

PATIENT INFORMATION - PLEASE SEND COPY OF PATIENT IDENTIFICATION (DRIVERS LICENSE OR PASSPORT & SOCIAL SECURITY CARD)

Patient Name:	Language Spoken:
Date of Birth: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Emergency Contact Name:
Social Security #	Emergency Contact Phone:
Maiden Name:	Relationship to Patient:
Street Address:	Citizenship Status:
City State: Zip:	Have you ever been seen at UCI: Y / N DATE:
Phone (H): (C):	Ethnic Background:
Email	Marital Status:

INSURANCE INFORMATION - PLEASE SEND COPY OF INSURANCE CARDS (Front and back with legible member ID#)

Primary Insurance Carrier:	Secondary Insurance Carrier:
Member ID#	Member ID#
Guarantor:	Guarantor:
Insured SSN# Insured DOB:	Insured SSN# Insured DOB:

CLINICAL INFORMATION

Cause of Renal Failure:	HT:	WT:	BMI:
Dialysis: <input type="checkbox"/> Pre-dialysis <input type="checkbox"/> Hemodialysis <input type="checkbox"/> CAPD/CCPD	Past Medical History:		
Original Dialysis Start Date:	Past Surgical History:		
Dialysis Treatment Days: <input type="checkbox"/> M/W/F <input type="checkbox"/> T/TH/S <input type="checkbox"/> Other: Time/Shift:	History of Mental Illness:		
Previous Transplant: <input type="checkbox"/> YES <input type="checkbox"/> NO Organ: Date: Center:	Multi-Listed: <input type="checkbox"/> YES <input type="checkbox"/> NO Center:		
Currently Smoking: <input type="checkbox"/> YES <input type="checkbox"/> NO Packs per day? Drug Use: <input type="checkbox"/> YES <input type="checkbox"/> NO Type: Drinking: <input type="checkbox"/> YES <input type="checkbox"/> NO Frequency:	Recent Hospitalizations:		
Recent Hospitalizations:	Recent Testing/Location:		
Does Patient Have a Potential Living Donor? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE	Relationship To Donor:		

DIALYSIS CENTER / REFERRING PHYSICIAN

Dialysis Center:	Referring MD:
Street Address:	Street Address:
City State: Zip:	City State: Zip:
Phone:	Phone:
Social Worker:	Fax: