UCLA Health
Transplant Services
Kidney and Pancreas Transplant Program

UCLA Kidney and Pancreas Transplant Program Referral Form

Thank you for referring your patient!
To start the referral process, please fax the following documents to (310) 983-3620:
1) Referral Form, 2) Both sides of insurance card, 3) Insurance authorization and 4) 2728 Form, if on dialysis.
If you require additional assistance, please call (310) 825-6836.

Patient Information

Last Name: _____ First Name: _____ MI: _____ SSN: _____ Gender: M / F
DOB: ___/___/___ Address: _____ City: _____ State: _____ Zip: _____
Race / Ethnicity: _____ E-mail: _____
Home #: (___)___-___ VM: Y / N | Work #: (___)___-___ VM: Y / N | Cell / Other #: (___)___-___
Emergency Contact #: (___)___-___ Name: _____ Relationship: _____
Mother's Maiden Name: _____ Marital Status: _____
Citizenship Status: _____ Country Of Origin: _____

Primary Language: _____ Interpreter? Y / N Special Needs? Y / N

Physician Information

Referring Physician: _____
Practice / Group Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (___)___-___ Fax: (___)___-___
E-mail: _____

Primary Care Physician: _____
Practice / Group Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (___)___-___ Fax: (___)___-___
E-mail: _____

Insurance Information

Medicare #: _____ Medical #: _____ Health Plan: _____
HMO / PPO ID #: _____ Insurance Phone #: (___)___-___ Group #: _____
Are Patient Insurance Premiums Being Paid Thru American Kidney Fund? Y / N
Insurance Subscriber's Name: _____ Relationship To Patient: _____
Subscriber's DOB: ___/___/___ Subscriber's SSN: _____ Kaiser #: _____
Kaiser Facility: _____ Case Manager: _____

Patient's General Clinical and Dialysis Information

Dialysis: Y / N | Dialysis Days: MWF / TTS / PD / Other: _____ Date Of First Dialysis: ___/___/___
Name Of Dialysis Center: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (___)___-___ Fax: (___)___-___ Dialysis Unit Social Worker: _____
Height: ___' ___" Weight: _____ lbs / kg | BMI: _____ Date: ___/___/___
Cause Of Chronic Kidney Disease: _____
Most Recent Hospitalization Date: ___/___/___ Location: _____

UCLA MR #: _____ Living Donor Y / N Is Patient Able To Make Medical Decision? Y / N
History Of Previous Transplant? Y / N | If Yes, TX Date ___/___/___ Which Organ?
Is The Patient Currently Listed At Another TX Center? Y / N | Name Of TX Center:
Has the Patient Been Denied For TX At UCLA Or Other TX Center? Y / N | If So, Reason(s):
Ambulatory: Y / N | Reason: _____ Assisted Living Facility: Y / N