Keck Medical Center of USC
Keck Medicine of USC

ABDOMINAL TRANSPLANT REFERRAL FORM

Thank you for your referral to the Keck Medical Center of USC – Transplant Institute.
We will call the patient to schedule an appointment once the initial referral process is processed.

Referral Type: ☐ **Transplant Evaluation** ☐ **Post-Transplant Management**
Organ (check all that apply): ☐ Liver ☐ Liver/Kidney ☐ Kidney ☐ Kidney/Pancreas ☐ Pancreas only
Referring Diagnosis/es:

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Age _____ Sex ☐ M ☐ F Height _____ Weight _____ Primary language _____

Primary Phone _____ Alternate Phone _____ Email address _____

Emergency Contact Person _____ Relationship: _____ Phone _____

MEDICAL INSURANCE (Primary)

Healthplan: _____ Subscriber ID: _____

Medical Group: _____ Case Manager: _____ Phone : _____

MEDICAL INSURANCE (Secondary)

Healthplan: _____ Subscriber ID: _____

Medical Group: _____ Case Manager: _____ Phone: _____

DIALYSIS INFORMATION

Dialysis Center: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

1st date of Dialysis (Ever) _____ Dialysis days/time ☐ M-W-F
☐ T-Th-S

Type of Dialysis: ☐ HD ☐ PD ☐ Pre-Dialysis

REFERRING MD INFORMATION

Referring MD _____
Specialty _____
Phone _____ Fax _____
Address _____
City _____ State _____ Zip _____

PRIMARY CARE MD INFORMATION

PCP _____
Specialty _____
Phone _____ Fax _____
Address _____
City _____ State _____ Zip _____

Complications (Please check all that apply): ☐ Jaundice ☐ Variceal Bleeding ☐ Rejection/Graft Failure ☐ Ascites ☐ HCC/Liver Cancer ☐ Limited Dialysis Access

In order to schedule your patient, please fax this form and the items listed below to:

Fax: 323.442.6186 ATTENTION: Abdominal Transplant Referral

- ☐ **Copy of Insurance Card(s)** – HMO Authorization (if insurance is an HMO)
- ☐ **Latest History & Physical** or Latest Progress Note/s
- ☐ **Current Labs (within the last 1 month)** (please include CBC, CMP, AFP, Serology's, PT/INR)
- ☐ **Latest Imaging Studies – Abdominal US/CT scan or MRI (done within the last 6 months)** and/or mammogram, pap smear, etc.
- ☐ **Latest Testing Results (done within the last year)** (2D Echo, Stress Test, Cardiac Cath, etc., EGD/Colonoscopy – if Available)
- ☐ If patient is Jehovah's Witness, ABO Blood Type **Required (for Liver referrals)**
- ☐ **List of medications**
- ☐ **2728 Form (ESRD/Dialysis form),** if applicable
- ☐ **Dialysis Social Work Assessment** – Applicable for **Kidney and Kidney/Pancreas Referrals**

Name of Person Completing this Form: _____ Title: _____
Phone: _____ Fax: _____ Date: _____