UPMC LIFE CHANGING MEDICINE

**Phone: 717-231-8727**
**Fax: 717-231-8753**

**For Office Use Only:**
Referral form given to RN: ______
Education: ______
Evaluation: ______

# TRANSPLANT NEW PATIENT REFERRAL INFORMATION

Referral Date: ______

**Name:** ______

Maiden Name: ______ Date of Birth: ______

Social Security Number: ______ Marital Status: ______

Race: ______ Gender Identity: ☐ Male ☐ Female

Primary Language: ______

Home Address: ______

City: ______ State: ______ ZIP: ______

Smoker: ☐ YES ☐ NO
Diabetic: ☐ YES ☐ NO
How long? ______
On Insulin? ☐ YES ☐ NO
Heart Stents or surgery? ☐ YES ☐ NO
Height: ______
Weight: ______

Email: ______ Veteran: ☐ YES ☐ NO Branch: ______

Phone: ______

Emergency Contact Name: ______

Relationship: ______ Phone: ______

**Full name of referring nephrologist:** ______

Address: ______

City: ______ State: ______ ZIP: ______

Phone: ______ Fax: ______

**Primary Care physician:** ______

PCP address: ______

City: ______ State: ______ ZIP: ______

Phone: ______ Fax: ______

**Cause of Kidney Disease:** ______

Is the patient currently listed or being evaluated at another transplant center? ☐ YES ☐ NO

If yes, what center? ______

Dialysis Unit: ______ Dialysis phone number: ______

Type of Dialysis: ______

Days of dialysis: ______

Start Date of Dialysis: ______ **Please fax a copy of patient CMS2728 and recent labs**

Insurance carriers: ______

**Please fax copies of the front and back of ALL insurance and prescription cards**