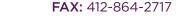


## PERSONAL INFORMATION SHEET

Kidney/Pancreas Does the patient have a living donor?  Have they previously had a transplant? yes History of cancer?  PATIENT INFORMATION  Last name:	
PATIENT INFORMATION  Last name:  First name:  Sex:  DOB:  Address:  History of cancer?  Docologist name:  History of diabetes?  yes  On insulin?  What is their height and weight?  Height:  Weight:  BMI:  Best time to contact:  DIALYSIS INFORMATION  Primary care physician name:  Address:  Phone:  Fax:  Dialysis address:  Dialysis fax:  Please include CMS 2728 form with referral.  Self-referred  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  DELAM#:  GROUP#:  Bate:  Oncologist name:  History of cancer?  Date:  Oncologist name:  History of cancer?  Plate:  Oncologist name:  History of cancer?  Plate:  Oncologist name:  History of cancer?  Oncologist name:  History of diabetes?  What is their height and weight?  Height:  Weight:  BMI:  Dialysis address:  Dialysis address:  Dialysis fax:  Please include CMS 2728 form with referral.  Self-referred  MEDICARE  Part B:  EFFECTIVE DATE:	no
Date:  First name:  Sex: DOB: On insulin? yes  Address:  Home phone: What is their height and weight?  Height: Weight: BMI:  Best time to contact::  DIALYSIS INFORMATION  PRIMARY/RENAL PHYSICIAN INFORMATION  Primary care physician name: Dialysis address:  Phone: Fax: Dialysis fax:  Phone: Fax: Please include CMS 2728 form with referral.  Self-referred  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  MEDICARE  DESTRUCTOR OF THE PROVIDER  MEDICARE  JOHN STATE SERVICE OF THE PROVIDER  MEDICARE  JOHN STATE SERVICE OF THE PROVIDER  MEDICARE  JOHN STATE SERVICE OF THE PROVIDER OF THE P	no
Last name:  First name:  Sex: DOB: DOB: On insulin? yes  Address: What is their height and weight?  Cell phone: Weight: Weight: BMI:  DIALYSIS INFORMATION  PRIMARY/RENAL PHYSICIAN INFORMATION  Primary care physician name: Dialysis address:  Phone: Fax: Dialysis fax:  Phone: Fax: Please include CMS 2728 form with referral.  Self-referred  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  ID: Yes no  PART B:  GROUP#: EFFECTIVE DATE:	no
First name:  Sex: DOB:	
Sex:	
Address: Home phone: Cell phone: Best time to contact:  DIALYSIS INFORMATION PRIMARY/RENAL PHYSICIAN INFORMATION Primary care physician name: Address: Phone: Fax: Dialysis phone: Please include CMS 2728 form with referral. Self-referred  INSURANCE INFORMATION HMO: yes no PPO: yes no INSURANCE PROVIDER ID: PLAN#: GROUP#:  EFFECTIVE DATE:  What is their height and weight? Height: Weight: BMI: BMI: BMI: BMI: BMI: BMI: BMI: BMI	no
Cell phone:	no
Best time to contact:	
PRIMARY/RENAL PHYSICIAN INFORMATION  Primary care physician name:  Address:  Phone:  Fax:  Dialysis address:  Dialysis phone:  Dialysis fax:  Please include CMS 2728 form with referral.  Self-referred  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  DIALYSIS INFORMATION  MEDICARE  JUNE 10	
PRIMARY/RENAL PHYSICIAN INFORMATION Primary care physician name: Address: Phone: Fax: Dialysis address: Dialysis fax: Please include CMS 2728 form with referral. Self-referred  INSURANCE INFORMATION HMO: yes no PPO: yes no INSURANCE PROVIDER D: USURANCE PROVIDE	
Address:  Phone:  Fax:  Dialysis phone:  Dialysis fax:  Please include CMS 2728 form with referral.  Self-referred  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  Dialysis phone:  Please include CMS 2728 form with referral.  Self-referred  MEDICARE  yes no  PLAN#:  GROUP#:  EFFECTIVE DATE:	
Phone: Fax: Dialysis fax: Please include CMS 2728 form with referral.  Nephrologist: Self-referred  Address: Fax: Self-referred  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  ID: yes no  PLAN#: PART B: EFFECTIVE DATE:	
Nephrologist:	
Nephrologist:	
Address:  Phone:  Fax:  INSURANCE INFORMATION  HMO: yes no PPO: yes no  INSURANCE PROVIDER  MEDICARE  JU:  yes no  PLAN#:  GROUP#:  EFFECTIVE DATE:	
Phone:         Fax:           INSURANCE INFORMATION           HMO:         yes         no           INSURANCE PROVIDER         MEDICARE           ID:         yes         no           PLAN#:         PART B:           GROUP#:         EFFECTIVE DATE:	
HMO:         yes         no         PPO:         yes         no           ID:         yes         no           PLAN#:         PART B:         EFFECTIVE DATE:	
HMO:         yes         no         PPO:         yes         no           ID:         yes         no           PLAN#:         PART B:         EFFECTIVE DATE:	
INSURANCE PROVIDER  ID:	
D:	
PLAN#: PART B:  GROUP#: EFFECTIVE DATE:	
GROUP#: EFFECTIVE DATE:	
EEE DATE: MEDICAID	
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PHONE #: yes no	
RECIPIENT#:	







## IMPORTANT INFORMATION TO SEND WITH A KIDNEY TRANSPLANT REFERRAL TO UPMC:

Always include the CMS 2728

Include progress notes x 3 months Include 3 dialysis flow sheets

Include recent labs x 3 months as well as History and Physical

## Please send any available relevant diagnostic testing such as:

EKG Mammogram
GFR Pap Smear

Echocardiogram COLOGUARD or Colonoscopy with Pathology

Nuclear Stress Test/Cardiac catheterization Pathology of Kidney Biopsy

CXR Endocrinology Visit for Pancreas Referral (if available)

Ultrasound or CT scan of the abdomen PSA

## Please include in the email <u>UPMCKidneyReferrals@upmc.edu</u> any concerns pertaining to the patient including:

BMI over 42

Recent or current cancer

Issues with caregiver or transportation availability

Non-compliance with medical regimen

Under-treated mental illness or behavioral problems

Residing in an institution or long-term care setting

Recent debilitating illness

Wheelchair/cane

Oxygen

Any other pertinent information.