UPMC | TRANSPLANT SERVICES

FAX: 412-864-2717
email: UPMCKidneyReferrals@upmc.edu

PERSONAL INFORMATION SHEET

TYPE OF TRANSPLANT

- ☐ **Kidney**
- ☐ **Kidney/Pancreas**
- ☐ **Does the patient have a living donor?**

PATIENT INFORMATION

Last name:_____

First name:_____

Sex:_____ DOB:_____

Address:_____

Home phone:_____

Cell phone:_____

Best time to contact:_____

PRIMARY/RENAL PHYSICIAN INFORMATION

Primary care physician name:_____

Address:_____

Phone:_____ Fax:_____

Nephrologist:_____

Address:_____

Phone:_____ Fax:_____

MEDICAL HISTORY

Is the patient on hemodialysis or peritoneal dialysis? ☐ yes ☐ no

Have they previously had a transplant? ☐ yes ☐ no

History of cancer? ☐ yes ☐ no

Date:_____

Oncologist name:_____

History of diabetes? ☐ yes ☐ no

On insulin? ☐ yes ☐ no

What is their height and weight?

Height:_____ Weight:_____ BMI:_____

DIALYSIS INFORMATION

Dialysis clinic:_____

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

ID:_____

PLAN#:_____

GROUP#:_____

EFF DATE:_____

PHONE #:_____

MEDICARE

☐ yes ☐ no

PART B:_____

EFFECTIVE DATE:_____

MEDICAID

☐ yes ☐ no

RECIPIENT#:_____

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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
- ☐ GFR
- ☐ Echocardiogram
- ☐ Nuclear Stress Test/Cardiac catheterization
- ☐ CXR
- ☐ Ultrasound or CT scan of the abdomen
- ☐ Mammogram
- ☐ Pap Smear
- ☐ COLOGUARD or Colonoscopy with Pathology
- ☐ Pathology of Kidney Biopsy
- ☐ Endocrinology Visit for Pancreas Referral (if available)
- ☐ PSA

Please include in the email UPMCKidneyReferrals@upmc.edu 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.