

KIDNEY TRANSPLANT REFERRAL FORM

Patient Information

Name (Last): _____ (First): _____ (Middle Initial): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Ht: _____ Wt: _____

Current mailing address: _____ City/St/Zip: _____

Phone #1: _____ Phone #2: _____

Interpreter needed? ☐ No ☐ Yes, language: _____

Blood type: ☐ A ☐ B ☐ O ☐ AB ☐ Unknown

Dialysis type: ☐ Hemodialysis ☐ Peritoneal dialysis ☐ N/A - not on dialysis

Dialysis Facility: _____ Days: ☐ M-W-F ☐ T-Th-S Shift: _____

Nephrologist: _____ ☐ I have discussed this referral with the patient's nephrologist

Required Clinical Information To Process This Referral Timely

- ☐ A provider note (preferably Nephrologist) that contains the cause of ESRD, past medical, and surgical history. It is helpful to include comments on the patient's general health status, compliance, any concerns/issues, etc.
- ☐ Current list of medications
- ☐ Psychosocial concerns, if any
- ☐ Recent lab results (must include first GFR ≤ 25 if not on dialysis)
- ☐ Two-page Medicare 2728 Form (if on dialysis)
- ☐ Legible FRONT and BACK copy of all insurance and prescription cards
- ☐ Patient to complete and sign the *Patient Health Questionnaire for Kidney Transplant Evaluation* form (submit w/ referral)

Referral form completed by: _____ Date: _____ Time: _____

FAX THIS FORM AND ABOVE ITEMS TO (808) 691-8896 OR MAIL TO: Queen's Transplant Center
550 S. Beretania Street, Suite 404
Honolulu, Hawaii 96813

Reminder: The Queen's Transplant Center kidney transplant education video (on CD or our website) and Explore Transplant patient education material can assist with educating your patient on transplant and living kidney donation.

For more information, visit www.queens.org/transplant or call (808) 691-8897. Thank you for your referral!

..... For Transplant Internal Use Only.....

Date received: _____

By: _____

Date mailed letter: _____