OHSU Transplant Referral Form

Patient information

Patient name: Date of birth:

Please evaluate patient for:

◯ Kidney transplant ◯ Simultaneous pancreas and kidney transplant ◯ Simultaneous liver and kidney transplant

Please include the following records for all referrals:

◯ Patient's most recent H&P (must be within the last 12 months) ◯ Patient's most recent renal function lab results ◯ Vaccine history

Please include the following for patients on dialysis:

◯ Medicare 2728 (if on dialysis) ◯ Rounding Report or Treatment Log (if on dialysis)

◯ Dialysis type: ◯ Dialysis unit:

Please include the following for patients with prior transplant history:

◯ Organ transplanted: ◯ Date of transplant:

◯ Transplant center name:

Concerns or special notes regarding this referral (non-compliance, drug use, tobacco use, psychosocial):

Insurance information

Primary insurance: ID #:

Subscriber: Group #:

Secondary insurance: ID #:

Subscriber: Group #:

Medicare Part D ID: Group #:

Bin: Phone no.:

If we have questions or need additional information, please include contact information for referring clinic (nephrology or dialysis):

Name: Phone no.:

OHSU