UC Health

Kidney/Pancreas Transplant Referral Form

Referral Date: **Type of Referral:** ☐Kidney ☐Kidney/Pancreas ☐Pancreas

Diagnosis Causing Kidney Failure/ESRD: _____

First Name **Last Name** **M.I.**		**Maiden Name:** **Gender:** ☐Male ☐Female
Date of Birth:	**Social Security Number:**	**Home Phone # : ( )**
Address: (include Apt #, if applicable) **City, State, Zip Code**		**Cell Phone #: ( )** **Marital Status:** ☐Single (never married) ☐Separated ☐Married ☐Divorced ☐Widowed ☐Unknown
Race: ☐Caucasian ☐African American ☐American Indian/Native Alaskan ☐Asian ☐Mid-East/Arabian ☐Other	**Ethnicity:** ☐Hispanic Origin ☐Non-Hispanic Origin ☐Unknown **Citizenship (country):**	
Referring Physician Name:	**Referring Physician Phone #:** ( )	**Referring Physician FAX #:** ( )
Referring Physician Mailing Address: **City, State, Zip Code**		
Dialysis Type: ☐Pre-Emptive (not on dialysis) ☐Peritoneal Dialysis ☐Hemodialysis	**Dialysis Days:** ☐Monday, Wednesday Friday ☐Tuesday Thursday, Saturday ☐Other:	**Dialysis Facility:** **Address:**
Is patient listed at another facility? ☐No ☐**Yes** **Where:**	**Has this patient had a previous transplant?** ☐No ☐**Yes** **If Yes, Where:** **When:** **Type:**	**Phone #: ( )** **FAX #: ( )** **Pt. Height:** **Weight:** **lbs.**
Employment Status: ☐ Full Time ☐ Part Time ☐ Not Working due to Disability ☐ Not Working by choice ☐ Temporarily unemployed ☐ Student ☐ Retired	**Primary Insurance:** Effective Date: ID #: Group# Prior Authorization Phone #: **Secondary Insurance:** Effective Date: ID #: Group# Prior Authorization Phone #:	

The following REQUIRED DOCUMENTS MUST accompany this referral. If documents are not available, document reason why in comment section. Failure to send documents may substantially delay the referral from being processed.

☐ 2728 Form
☐ Enlarged copy of Insurance Cards
☐ **Current HOME** Medication List
☐ Most Recent MD/Nephrology Consult Note **INCLUDING a** History & Physical
☐ Labs **WITHIN 30 days** of referral
☐ Vaccinations/Immunization Record
☐ UCMC Release of Information
☐ Demographics Page

Comments:

If you have any questions, please call the Transplant Assistant at (513) 584-7001, Option 1 OR Toll-Free: 1(855) 465-4363. Address: 234 Goodman Street, ML0597B, Cincinnati, OH 45219

Please FAX this form AND required documents to: (513) 584-0881