

Kidney Transplant Candidate Referral Form

Referral Date: _____ Referred By: _____

Patients Name: _____ SS#: _____ DOB: _____ Race: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell: _____ Emergency Contact: _____

Height: _____ Weight: _____ BMI: _____ (Patient's BMI must be ≤ 38 to be considered for evaluation)

Nephrologist: _____ Primary Physician: _____

Dialysis Patient: Yes No / Type of Dialysis: Hemodialysis CAPD / Dialysis Start Date: _____

Dialysis Center: _____ Phone: _____ Dialysis Days: _____ Shift: _____

Is the patient listed at another transplant facility: Yes No If yes, Where: _____

Please include the information below with this referral form:

- | | | |
|---|---|--|
| <input type="checkbox"/> Patient history and physical | <input type="checkbox"/> Copy of insurance cards | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Current lab values | <input type="checkbox"/> Missed dialysis treatment report (1 year) | <input type="checkbox"/> Record of recent vaccines |
| <input type="checkbox"/> Nephrology dialysis notes | <input type="checkbox"/> Test or procedure results (CXR, stress test, US, etc.) | <input type="checkbox"/> 2728 form |

This referral cannot be initiated unless it is completed in its entirety and, when applicable, all requested documents must accompany this form.

**PLEASE FAX THIS FORM ALONG WITH ALL REQUESTED INFORMATION TO LUTHERAN
TRANSPLANT CENTER @ 260-435-6279**

7910 W. Jefferson Blvd / Suite 200 / Fort Wayne / IN / 46804

Thank you,

The Lutheran Kidney Transplant Team